TennCare Operational Protocol

Incorporating Amendments to the Demonstration Approved in 2005

Bureau of TennCare Nashville, Tennessee

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List of Abbreviations Used in This Document

ACCENT Automated Client Certification and Eligibility Network for Tennessee

ADA-CDT American Dental Association—Current Dental Terminology

AHR Ad Hoc Report

ALJ Administrative Law Judge

APSP Adjusted Periodic Screening Percentage

AS Administrative Simplification

ASO Administrative Services Organization BHO Behavioral Health Organization BIPA Benefits Improvement Protection Act

BPN Best Practice Network CAP Corrective Action Plan

CBER Center for Business and Economic Research
CDC Centers for Disease Control and Prevention
CAHPS Consumer Assessment of Health Plans Study

CHIP Children's Health Insurance Program
CMHA Community Mental Health Agency
CMHC Community Mental Health Center

CMS Centers for Medicare and Medicaid Services
COBRA Consolidated Omnibus Budget Reconciliation Act

CPE Certified Public Expenditure
CPT Current Procedural Terminology
CRA Contractor Risk Agreement
CRG Clinically Related Group
CSA Community Service Area

CY Calendar Year

DBM Dental Benefits Manager

DCI See TDCI
DCS See TDCS

DESI Drug Efficacy Study Implementation

DHS See TDHS
DMHDD See TDMHDD
DMRS See TDMRS
DOH See TDOH

EBT Electronic Benefit Transfer

EPSDT Early and Periodic Screening, Diagnosis, and Treatment

EQRO External Quality Review Organization

FFP Federal Financial Participation

FFY Federal Fiscal Year (October 1 through September 30)

FPL Federal Poverty Level

FQHC Federally Qualified Health Center

FTP File Transfer Protocol

FY Fiscal Year

HCBS Home and Community Based Services
HCFA Health Care Financing Administration
HCPCS HCFA Common Procedure Coding System

HIPAA Health Insurance Portability and Accountability Act

HIPP Health Insurance Purchasing Program
HMO Health Maintenance Organization

HEDIS Health Plan Employer Data and Information Set ICD-9 International Classification of Diseases, 9th Revision ICF/MR Intermediate Care Facility for the Mentally Retarded

IHS Indian Health Service
IRS Internal Revenue Service
IRS Identical, Related, and Similar

IS Information Systems LTE Less Than Effective

MCC Managed Care Contractor
MCO Managed Care Organization

ME Medically Eligible

MEI Medicare Economic Index

MEQC Medicaid Eligibility Quality Control

MR Mental Retardation

NACDS National Association of Chain Drug Stores

NAIC National Association of Insurance Commissioners
NCPDP National Council for Prescription Drug Programs

NCQA National Committee for Quality Assurance

NF Nursing Facility

NSF National Standard Format

OCCP Office of Contract Compliance and Performance

OGC Office of General Counsel

OOP Out-of-Pocket
ORR On Request Report

PBM Pharmacy Benefits Manager

PCP Primary Care Provider

PLHSO Prepaid Limited Health Service Organization

PMPM Per Member Per Month

POS Point of Service

PPS Prospective Payment System
PSA Public Service Announcement
QMB Qualified Medicare Beneficiary
QMP Quality Monitoring Program
SED Seriously Emotionally Disturbed

SFY State Fiscal Year (July 1 through June 30)
SLMB Special Low-Income Medicare Beneficiary

SPA State Plan Amendment

SPMI Severely and/or Persistently Mentally III

SSA Social Security Administration SSI Supplemental Security Income

SSN Social Security Number

STCs Special Terms and Conditions
TANF Temporary Aid to Needy Families
TBI Tennessee Bureau of Investigation

TCMIS TennCare Management Information System

TDCI Tennessee Department of Commerce and Insurance

TDCS Tennessee Department of Children's Services
TDD Telecommunications Device for the Deaf
TDHS Tennessee Department of Human Services

TDMHDD Tennessee Department of Mental Health and Developmental Disabilities

TDMRS Tennessee Division of Mental Retardation Services

TDOH Tennessee Department of Health

TM **Transitional Medicaid** Third Party Administrator TPA

Tennessee Pharmacists Association TPA TennCare Partners Advocacy Line TPAL

Target Population Group TPG TPL

Third Party Liability
TennCare Standard Operating Procedure
TennCare Solutions Unit TSOP

TSU

List of "User Friendly" Definitions

Note: For legal purposes, the definitions in the state rules and the state's contracts are to be used. The following list is intended to provide "user friendly" definitions for general reference only.

Applicant. A person who has applied for TennCare but whose application has not been approved or denied.

Authorization date. The date that an application from a person in the demonstration population has been approved for TennCare.

Case. A household which includes some members who are TennCare eligible.

Closed enrollment. A period of time during which the only persons who can enroll in TennCare as new members are those found eligible in a continuing category of Medicaid.

Continuous enrollment. A period of time during which enrollment is open without interruption. Continuous enrollment is available year-round for Medicaid eligibles. Continuous enrollment is also available year-round for persons under age 19 classified as "Medicaid Rollovers." Persons who are under age 19 whose Medicaid eligibility is ending, who are uninsured, AND who have incomes below 200% of poverty OR who have been determined "Medically Eligible" at any income level are eligible to rollover to TennCare Standard. Medicaid Rollovers must complete their applications within specified time periods.

Consumer Assessment of Health Plans Study (CAHPS). A set of standardized surveys that measure patient satisfaction with experience of care. CAHPS is sponsored by the Agency for Health Care Quality.

Demonstration eligible. Persons who are not eligible under Tennessee's State Plan but who are otherwise eligible for the TennCare demonstration project (otherwise known as "TennCare Standard.").

Demonstration project. A project approved by the Centers for Medicare and Medicaid Services, which allows certain Medicaid statutes and regulations to be "waived" for the purpose of "demonstrating" or "testing" a principle or set of principles about health care. TennCare is a demonstration project designed to show that a managed care approach can be used to extend coverage to people who would not otherwise be eligible for Medicaid, without costing the state more money than the state would have spent on a Medicaid program only and without compromising service quality.

Disenrollment. The process by which a person who has lost eligibility for TennCare is removed from the program.

Eligible. A person who has been determined eligible for TennCare.

Enrollee. A person who has been determined eligible for TennCare and who has been enrolled in the program.

Family. Parents and related children who live together in the same household. "Related" individuals include parents' spouses who live in the home, as well as siblings, half-siblings, and step-siblings. Caretakers (such as grandparents) who are not parents but who are present in the home are not included in the definition of "family" unless they request to be included. Children living at home are removed from the "family" once they turn 19 (for TennCare Standard) or 21 (for TennCare Medicaid) or they marry, whichever comes first.

Health Plan Employer Data and Information Set (HEDIS). The most widely used set of performance measures in the managed care industry, designed to allow reliable comparison of the performance of managed health care plans. HEDIS is developed and maintained by the National Committee for Quality Assurance.

Immediate eligibility. A process by which children entering state custody (other than those going into Youth Development Centers) are assigned to TennCare Select so that they can start receiving health care services immediately. If the result of the eligibility determination process is that the child is not eligible for TennCare, DCS will refund to TennCare Select any payments made on the child's behalf.

Income. Income such as salaries, wages, pensions, certain rental income, interest income, dividends, royalties, etc., which produce a gain or a benefit to the recipient.

Institutionalized. TennCare enrollees who are receiving long term care in nursing facilities, an intermediate care facilities for the mentally retarded, or under a home and community based services waiver program.

Marketing. TennCare uses the term "marketing" to refer to all contacts made by managed care entities with enrollees, including letters, enrollee satisfaction surveys, newsletters, etc.

Medicaid. The program for medical assistance provided under Title XIX of the Social Security Act for certain persons with low incomes and special circumstances. Medicaid programs are administered jointly by the state and the federal government.

Medicaid eligible. People who are eligible under Tennessee's State Plan (otherwise known as "TennCare Medicaid").

Medicaid Rollover. Persons who are under age 19 whose Medicaid eligibility is ending, who are uninsured, AND who have incomes below 200% of poverty OR who have been determined "Medically Eligible" at any income level are eligible to rollover to TennCare Standard. Medicaid Rollovers must complete their applications within specified time periods.

Medically Eligible. An uninsured person under age 19 who is not Medicaid eligible, and who qualifies for TennCare Standard based on certain medical conditions.

Medicare. The program for medical assistance provided under Title XVIII of the Social Security Act for elderly and certain disabled individuals. The Medicare program is administered solely by the federal government.

National Committee for Quality Assurance (NCQA). A nonprofit organization committed to assessing, reporting on and improving the quality of care provided by organized delivery systems. Useful information on NCQA may be accessed at the NCQA website: www.ncqa.org

Presumptive eligibility. An established period of time (45 days) during which certain individuals—pregnant women; women identified by the Centers for Disease Control and Prevention (CDC) as being uninsured and needing treatment for breast or cervical cancer—are eligible for Medicaid. During this period of time the presumptively eligible person must complete an application for Medicaid in order to stay on the program.

Redetermination. The process that occurs for TennCare Standard prior to disenrollment form the TennCare program, to determine whether they may continue to qualify for the program.

Resources. Assets such as savings accounts, personal property, etc., which are available to a individual. Resources are not counted for persons in the demonstration population.

Retrospective eligibility. Eligibility which begins as of a date in the past. Many Medicaid eligibles will have some level of retrospective eligibility—generally just a few days, except in the case of SSI eligibles, whose eligibility, once established, goes back to the date of application for SSI. Medicaid eligibles do not get automatic periods of retroactive eligibility in Tennessee as they do in other states. This regulation was "waived" for the TennCare demonstration project, since it is difficult to manage care for people whose enrollment date is prior to their enrollment into a managed care plan.

Reverification. The annual process that occurs for all demonstration eligibles during which they must provide documentation that they continue to meet the eligibility requirements for TennCare in order to stay on the program.

Spend down. A Medicaid category that is open for certain persons (children; pregnant women) who have incurred enough uncompensated medical bills to "spend down" their monthly income to a very low level.

Transitional Medicaid. The availability of continuing Medicaid coverage for a period after an individual has ceased receiving benefits under the Families First (TANF) program.

Uninsurable. Under the previous TennCare demonstration, a person who did not have insurance, who did not have access to insurance other than Medicare, and who had been turned down for insurance because of a health condition. This category is replaced by "Medically Eligible" in the new demonstration.

Uninsured. A person who is not insured and who lacks access to group health insurance.

Waiver. See definition of Demonstration Project.

Understanding TennCare Terms

TennCare is the name for the state's Section 1115(a) managed care demonstration.

TennCare Select is the name of the managed care plan that is contracted by the state to handle special populations of enrollees with complex medical needs and to be available in any area where there is inadequate MCO capacity. TennCare Select is also intended to serve as a back-up if one of the other managed care plans leaves the project unexpectedly.

TennCare Partners is the portion of the TennCare project that deals with behavioral health services.

TennCare Medicaid is the name for the package of benefits available for people who are eligible for Medicaid.

TennCare Standard is the name for the package of benefits available for people who are uninsured and Medically Eligible.

TennCare Assist is the name for the employer-subsidized insurance project. No employer-sponsored health insurance subsidy is envisioned at this time.

Part One: Overview

A. Organizational and Structural Configuration of the Demonstration Amendments

Background

On January 1, 1994, the state of Tennessee implemented the TennCare demonstration (No. 11-W-00002/4) as a five year demonstration project approved by the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) under Section 1115 of the Social Security Act. A three-year extension of the demonstration was granted through December 2001. Early in 2002, a one-year extension was granted to continue the demonstration through January 31, 2003.

A set of project modifications for a new TennCare demonstration was requested from CMS early in 2002. The new demonstration, which replaced the previous TennCare demonstration, was approved in May 2002 for an effective date of July 1, 2002. The number of the new demonstration is No. 11-W-00151/4.

On September 24, 2004, the Bureau of TennCare requested a number of modifications to the TennCare demonstration project. Following submission of this request, subsequent meetings with the public, and enrollee advocates in particular, the Bureau submitted a supplement to the September proposals on February 18, 2005. These changes were requested in order to stabilize and protect the TennCare project. In separate letters dated March 24, 2005 and June 8, 2005, CMS approved several of the modifications requested, while others remain under review. This Operational Protocol provides details on the implementation of the amended demonstration project.

Organization and Structure

The TennCare demonstration project is administered by the Bureau of TennCare, which is a division of the Tennessee Department of Finance and Administration. The Department of Finance and Administration oversees all state spending, and the Commissioner of the department serves as Chief Financial Officer to the Governor.

The Bureau of TennCare is headed by a Deputy Commissioner. Divisions within the Bureau include:

- Office of the Medical Director
- Operations
- Member Services
- Network Operations
- Financial Operations
- Information Systems
- Policy
- Office of General Counsel
- Long-Term Care¹
- Public Affairs
- Internal Audit
- Non-discrimination Compliance and Health Care Disparities

¹ The Long-Term Care Division oversees the nursing facility programs and the Home and Community Based Services waivers. While these programs are outside of the TennCare waiver, persons enrolled in these programs are also enrolled in TennCare.

An abbreviated organization chart for the Bureau of TennCare can be found in Attachment A.

Other state departments administer portions of the TennCare project, under the direction of the Single State Agency (the Department of Finance and Administration). These state departments, together with the specific TennCare functions that they carry out, are shown in the table below.

Table 1
State Agencies Involved in the TennCare Demonstration Project

Agency	Functions
Office of the Comptroller	 Performance of TennCare audits Performance of MCO and BHO audits Quarterly audits of the implementation of the <i>Grier</i>
	Consent DecreeEstablishment of Nursing Facility and ICF/MR rates
Department of Children's Services	 Determination of Medicaid eligibility for children coming into custody Provision of targeted case management for TennCare-eligible children in state custody and at risk of state custody
	 Provision of residential treatment services for TennCare-eligible children in state custody
Department of Commerce and	 Licensure of HMOs/MCOs, PLHSOs/BHOs, and TPA/DBMs
Insurance	 Financial oversight of HMOs/MCOs, PLHSOs/BHOs, and TPA/DBMs Administration of the TennCare Claims Processing Panel and Independent Review Process for review of denied claims submitted by providers Establishment and enforcement of uniform claim form instruction standards Administration of annual MCO/BHO network adequacy study Operational oversight of HMOs, PLHSOs/BHOs and TPA/DBMs, including: monitoring financial solvency, oversight, and review and approval of holding company systems activities and transactions; oversight of timeliness and accuracy of claims processing and payment of provider claims; subcontract and provider agreement review and approval; review of evidence of coverage, including member handbooks and provider manuals; and state law and CRA compliance of HMO, PLHSO/BHO, TPA operational subcontractors
Department of Education	 Oversight of school-based services delivered outside the MCEs EPSDT outreach

Agency	Functions	
Department of Health	 EPSDT outreach EPSDT screenings Provision of dental screenings and services to children Presumptive eligibility determinations for pregnant women Presumptive eligibility determinations for uninsured women needing treatment for breast and/or cervical cancer Enrollee education and advocacy 	
Department of Human Services	 TennCare eligibility determinations Provision of education and assistance regarding the TennCare eligibility process Family assistance information line Appeals of eligibility-related issues 	
Department of Mental Retardation and Developmental Disabilities	 Oversight of the TennCare Partners Program Development of policy for the TennCare Partners Program Evaluation of the TennCare Partners Program Review of BHO provider networks 	
Division of Mental Retardation Services	Serves as Administrative Lead Agency for the Home and Community Based Services Waivers for Persons with Mental Retardation	
Governor's Office of Children's Care Coordination	Coordinates EPSDT activities among state departments	

A number of contractors are involved in delivering TennCare services. These contractors include all of the managed care entities (MCOs, BHOs, DBM, and PBM) plus others shown in the table below.

Table 2
Major TennCare Contractors

Contractor	Major Functions
EDS	 Claims processing for long-term care
	 Claims processing for Medicare crossover payments
	 Maintenance of eligibility subsystem
	 Maintenance of encounter data
	 Ad hoc and regular reports
Schaller-Anderson of	 Review of medical appeals
Tennessee	 Assistance with medical policy
Aon	 Actuarial studies
Blue Cross/Blue Shield	TennCare Select contract
of Tennessee	
Health Services	 Quality reviews of MCOs and BHOs
Advisory Group (EQRO)	Special studies

Provisions of the approved amendments to the TennCare demonstration are incorporated in the following chapters.

B. Evaluation Design

The purpose of the TennCare project is to demonstrate that a Medicaid managed care program can be organized in such a way as to save the state enough dollars to be able to expand coverage to people who are not Medicaid-eligible, while at the same time ensuring access to quality care for all enrollees.

There are many different evaluation mechanisms in place for various components of the TennCare project. The domains of the overall evaluation design, however, include the following:

- Spending on TennCare versus spending on Medicaid
- Access to care for enrollees
- Quality of care
- Enrollee satisfaction
- Health status indicators
- Stability and viability of health plans

TennCare has developed measures for each of the above elements. These measures, together with the frequency of use, are shown in Table 3 on the next page.

Table 3
Overall TennCare Evaluation Measures

Domain	Measures	Frequency of
		Measurement
Spending on	Budget neutrality tests	6 months after the
TennCare		end of an individual
versus		demonstration year (per Special Terms
spending on Medicaid		and Conditions)
Access to care	Findings from the CAHPS survey ² on the	Annually
for enrollees	categories of "Getting needed care" and "Getting needed care quickly."	Timidally
	Progress on selected HEDIS measures (e.g., Child and Adolescent immunization status and Breast and Cervical Cancer screening).	Annually
	Progress on EPSDT screening ratios, as reported on the CMS 416	Annually
	Responses to annual beneficiary satisfaction	Annually, in
	survey, "Time between attempt to make	September of each
	appointment and first availability of	year (per Special
	appointment," "Waits for appointments."	Term and
Quality of care	Findings from the CAHPS survey on the	Conditions) Annually
Quality of care	category "How well doctors communicate."	Airidally
	Progress on selected HEDIS measures, such as "Appropriate medications for people with asthma," "Cholesterol management after acute cardiovascular events," "Comprehensive diabetes care," Controlling high blood pressure," "Advising smokers to quit," and "Demonstration of clinical and service quality management."	Annually
	Progress on NCQA standards in areas such as "Disease management," "Use of clinical practice guidelines," and "Demonstration of clinical and service quality improvement."	Annually
	Medical record reviews of EPSDT screenings to determine the completeness of screenings.	Annually

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² Tennessee is requiring that all MCOs seek NCQA-accreditation beginning July 1, 2005, and be accredited within 18 months. In order to obtain NCQA accreditation, the MCO must contract with an independent survey vendor certified by NCQA to administer an annual standardized Consumer Assessment of Health Plan Survey (CAHPS).

Domain	Measures	Frequency of Measurement
	Responses to annual beneficiary satisfaction survey, "Quality of medical care received by heads of household," and "Quality of medical care received by children of heads of household."	Annually, in September of each year (per Special Term and Conditions)
	Analysis of Network Adequacy Report— to ensure that each MCC is delivering benefits within the required time frames, and that each MCC has an adequate provider network to ensure effective and efficient delivery of healthcare services to TennCare enrollees	Annually
	Annual Quality Survey which provides an overall, review analysis and recommendations of the MCCs overall integration of the health care delivery system and assessment of quality of care	Annually
Enrollee satisfaction	Responses to annual beneficiary satisfaction survey	Annually, in September of each year (per Special Term and Conditions)
	Findings from the CAHPS instrument on the following four overall ratings of consumer experience: "Rating of all health care," "Rating of health plan," "Rating of personal doctor," and "Rating of specialist seen most often." Composite results are based on consumer experience in the following three categories: "Claims processing," "Courteous and helpful office staff," and "Customer service."	Annually
Health status indicators	EPSDT compliance	Quarterly
indicators	Childhood immunization status	Annually, by DOH
	Inpatient admissions per 1,000	Quarterly
	Non-emergency ER visits per 1,000	Quarterly
Stability and viability of health care	MCO/BHO network adequacy study (performed by TDCI)	Annually
plans	Reviews of compliance by TDCI with prompt pay requirements	Monthly
	Reviews of compliance by TDCI with MCO/BHO net worth requirements	Quarterly

Reports on the findings associated with these measurements will be summarized in the quarterly and annual reports that TennCare files with CMS, pursuant to Special Terms and Conditions.

Part Two: Eligibility and Enrollment

A. Eligibility Criteria

Overview

This chapter provides a description of the populations included in TennCare. These include Medicaid eligibles, as well as non-Medicaid eligible children under the age of 19 who are the current remaining members of the "demonstration population." These groups are summarized in Table 4.

TennCare Medicaid

Applicants for Supplemental Security Income (SSI) apply for that program through the Social Security Administration (SSA). Once determined eligible by SSA, they are automatically enrolled in Medicaid, with an effective date assigned to them by SSA.

Other applicants for TennCare coverage are assessed for Medicaid eligibility, using the eligibility rules specified in the Tennessee State Plan for Medical Assistance, the State of Tennessee's Title XIX program. These eligibility determinations are conducted by the Tennessee Department of Human Services at local DHS offices throughout the state. As of the close of business on April 29, 2005, however, enrollment for the non-pregnant adult Medically Needy categories was closed to new applicants.

TennCare Standard

As of the close of business on April 29, 2005, TennCare Standard enrollment was closed to new applicants. Only children under the age of 19 already enrolled in TennCare Standard and those whose Medicaid eligibility is ending and who meet the TennCare Standard eligibility criteria either as Uninsured or as Medically Eligible are eligible for TennCare Standard. The eligibility criteria for TennCare Standard are presented herein.

The following groups are included in TennCare Standard:

- Uninsured low-income³ children:
- Uninsured Medically Eligible children;
- Uninsured children who were eligible for TennCare as of December 31, 2001, even if
 they had access to insurance but whose family incomes were below 200% poverty.
 In order to stay in this eligibility group, children must remain continuously enrolled,
 and they must continue to meet income standards, to be uninsured by other carriers,
 and to be under the age of 19.

This last of the eligibility groups for TennCare Standard is a "grandfathered" group from the previous TennCare project. All of the persons in this "grandfathered" group will continue to be enrolled in TennCare as long as they are continuously enrolled in their "grandfathered" category and they continue to meet all program requirements. If there is a break in coverage for any reason, such as non-payment of premiums, persons

³ Low income is defined by the Tennessee State Legislature as a percentage of the Federal Poverty Level and is annually established for purposes of TennCare Standard eligibility. The income level will not exceed 200% of FPL.

disenrolled from a "grandfathered" group will not be able to re-enroll in that group. They will be treated like new applicants if they apply again for TennCare. Persons in the "grandfathered" groups who become Medicaid-eligible will not be able to return to their "grandfathered" group when their eligibility for Medicaid ends. They will be allowed to apply for TennCare like other Medicaid Rollovers when their Medicaid is over.

Table 4
Eligibility Groups in the 2005 TennCare Demonstration

TennCare Project	Eligibility Group	Description
TennCare Medicaid	Group A	Tennessee residents who have been determined eligible for Medicaid.
	Group B	Tennessee women who are uninsured or whose insurance does not cover treatment for breast or cervical cancer, who are under age 65, and who have been determined through a Centers for Disease Control site to need treatment for breast or cervical cancer.
TennCare Standard	Group C	Tennessee residents who are children under age 19, who are uninsured, who do not have access to group health insurance, and who have incomes below 200% of poverty*.
	Group D	Tennessee residents at any income level* who are children under age 19, who are uninsured, who do not have access to group health insurance, and who are determined to be "Medically Eligible" by the state.
	Group E	Tennessee residents who were enrolled as uninsured children in TennCare as of December 31, 2001, even if they had access to insurance, because their family incomes were below 200% of poverty and who continue to meet the criteria of being under the age of 19 and with family incomes below 200% of poverty.

^{*}NOTE: Income levels are subject to revision downward, depending upon the funding level determined by the General Assembly and the availability of funds within the federal budget neutrality cap.

Persons meeting Medicaid eligibility criteria can enroll at any time. Uninsured children under age 19 whose Medicaid eligibility is ending but who qualify for TennCare Standard and file timely applications will be allowed to move immediately into TennCare Standard as Medicaid Rollovers, assuming they meet the income and/or Medical Eligibility criteria in place at the time. They will not experience a break in coverage.

1. TennCare Medicaid

All persons who would be eligible for Medicaid under the eligibility rules specified in Tennessee's State Plan for Medical Assistance (provided in accordance with Title XIX of the Social Security Act) are eligible for TennCare. Included in this group are categorically and medically needy individuals, as well as Medicare beneficiaries who are also eligible for Medicaid. Qualified Medicare Beneficiaries (QMBs) and Specified Low Income Medicare Beneficiaries (SLMBs) are covered for Medicare cost-sharing, but do

not participate in TennCare Medicaid unless they are also eligible in a Medicaid category.

2. TennCare demonstration population

The non-Medicaid demonstration population for TennCare is the population enrolled in TennCare Standard.

(a) Technical eligibility criteria

All members of the demonstration population must meet the following technical eligibility criteria: they must be residents of the State of Tennessee, they must be United States citizens or legal resident aliens, they must have met Social Security enumeration requirements, and they must not be incarcerated.

(b) Access to insurance

"Access to insurance" is a very important concept in TennCare. Persons in TennCare Standard must lack access to health insurance. The types of policies that count as "insurance" and the types of policies that do not count as "insurance" for purposes of determining uninsured status are presented in Table 5.

(c) Income levels

All persons in the demonstration population are screened for income. Resources are not counted.

The family income level is calculated by DHS according to the current federal poverty level (FPL) standards, using the same definitions of "family" and "income" that DHS uses for Medicaid applicants. Income is used to determine premiums to be paid to the state. For demonstration project eligibles, the income limit is set by the demonstration project and may be modified by the General Assembly each year. Those eligibles having family incomes at or greater than 100% of poverty will be required to pay premiums and copays. The pharmacy program has separate copay requirements which are discussed in Part 3 – B.

Table 5 Definitions of "Insurance" under TennCare

Types of Policies that Count as "Insurance"	Types of Policies that Do Not Count as "Insurance"
A hospital and medical expense-incurred policy,	Short-term coverage,
Medicare,	Accident coverage,
TRICARE,	Fixed indemnity insurance,
COBRA,	Long-term care insurance,
Medicaid,	Disability income contracts,
State health risk pool (Tennessee does not currently have such a pool),	Limited benefits policies, meaning a policy of health coverage for a specific disease (such as cancer), or
Nonprofit health care service plan contract,	an accident occurring while engaged in a specified activity (such as school-based sports), or a policy
Health maintenance organization subscriber contract,	which provides for a cash benefit payable directly to
An employee welfare benefit plan to the extent that the plan provides medical care to an employee or	the insured in the event of an accident or hospitalization (for example, hospital indemnity),
his/her dependents (as defined under the terms of the	Credit insurance,
plan) directly through insurance, any form of self- insurance, or a reimbursement mechanism, Coverage available to an individual through	School-sponsored sports-related injury coverage, Coverage issued as a supplement to liability
membership in a professional organization or a	insurance,
school,	Automobile medical payment insurance,
Coverage under a policy covering one person or all the members of a family under a single policy where the contract exists solely between the individual and the insurance company, or	Insurance under which benefits are payable with or without regard to fault and which are statutorily required to be contained in any liability insurance policy or equivalent self-insurance,
Any of the above types of policies which may have	A medical care program of the Indian Health Services
been termed "limited benefits" policies in the past	(IHS) or a tribal organization,
because:	Benefits received through the Veteran's Administration, or
The policy contains a type of benefit (such as	· ·
mental health benefits) which has been completely exhausted, The policy contains a type of benefit (such as pharmacy) for which an annual limitation has been reached. The policy has a specific exclusion or rider of noncoverage based on a specific prior existing condition or an existing condition or treatment of such a condition.	Health care provided through a government clinic or program such as, but not limited to, vaccinations, flu shots, mammograms, and care or services received through a disease- or condition-specific program such as, but not limited to, the Ryan White Act.
People with any of the types of policies listed above will be considered "insured" by TennCare even if one or more of the following circumstances exists: The policy contains fewer benefits than TennCare. The policy costs more than TennCare, The policy is one the individual could have bought during a specified period of time (such as COBRA) but chose not to.	

B. TennCare Eligibility Process

Overview

All applicants for TennCare, except SSI recipients and children in state custody, must complete a written application and be interviewed by a worker with the Department of Human Services (DHS). SSI applicants apply through the Social Security Administration (SSA) and are automatically enrolled in TennCare Medicaid upon approval of SSI benefits. Children coming into state custody are enrolled through the Department of Children's Services. They have access to an arrangement called "immediate eligibility," which is discussed in item 4 of this section.

Pregnant women can apply for presumptive eligibility status at local health departments and other sites designated by the Department of Health through the Title V agreement. If they meet the requirements, they become immediately eligible for 45 days of TennCare. They must follow up with applications through DHS in order to continue benefits past the 45-day period.

Women who are under age 65, who are uninsured or have insurance which does not cover treatment for breast or cervical cancer, and who have been determined to be in need of treatment for breast or cervical cancer may be screened for presumptive eligibility for Medicaid by a Centers for Disease Control and Prevention (CDC) site such as the health department. Presumptive eligibility lasts for a period of 45 days. During the presumptive eligibility period, the enrollee must go to the DHS office to complete her enrollment in Medicaid. The DHS worker first evaluates the woman to determine if she is eligible for any other Medicaid category. If she is not eligible in another Medicaid category, the worker evaluates her for the optional Medicaid category to cover her during the time she needs treatment for cervical or breast cancer. A redetermination of eligibility will occur at least every 12 months at the DHS office and will be based on the need for continuing treatment for breast or cervical cancer, as determined by the woman's treating physician.

Applicants other than SSI applicants usually complete a portion of the application prior to the actual face-to-face interview. During the interview, the DHS worker and the applicant(s) jointly complete the remainder of the application. Persons who are unable to complete the applicant sections of the full application are assisted by DHS workers during the interview process (see Procedures for Accommodations at the end of this section). Applicant information is keyed online during the interview (in most cases) or from a workbook manually completed by a DHS worker at a later time (only occasionally).

The state's automated eligibility system (ACCENT) determines Medicaid eligibility by category based on the information entered. Medicaid eligibility is determined within the time periods provided for in federal regulations, and the applicant is notified by DHS of the result of this process. Appeals of denials of Medicaid eligibility are handled by DHS.

Children under age 19 whose Medicaid eligibility is ending are screened for TennCare Standard. If the applicant lacks access to insurance and has income below the specified poverty level, she may be eligible for the TennCare Standard Uninsured category. If the applicant meets all the technical eligibility criteria for TennCare Standard and is ineligible solely because of excess income, the applicant is offered an opportunity to apply in the Medically Eligible (ME) category.

There are two options that an applicant may use to apply for Medical Eligibility. Both of the processes begin with an eligibility determination at the local Department of Human Services. Any child under age 19 whose Medicaid eligibility is ending, who is uninsured, and who meets

all of the technical requirements for TennCare Standard except for excess income will be given an opportunity to apply as Medically Eligible by completing a special packet. The options for Medical Eligibility are shown in Table 6.

Table 6
Options for Medical Eligibility

, ,	
Condition along support Tenn	applicant must either have his physician attest that he has a cal condition on the TennCare list, or the applicant must submit, with the completed application, appropriate medical records to ort the attestation of a medical condition not included on the Care list, and a release for additional medical records, if ssary.
Emot menta the T diagn Tenn data	ipplicant must have a recent assessment as SED (Serious ional Disturbance). She must provide attestation by a licensed all health professional of the diagnosis that supports the basis for PG assessment, as well as the medical records to support that osis. Care will review available encounter data and, if the encounter shows that the person has been assessed as SED within the year, she will not be required to submit additional medical

For Option 1 ("Qualifying Medical Condition"), TennCare has prepared a listing of diseases/conditions that will be used to determine Medical Eligibility (see Attachment B). The diseases/conditions selected represent serious and/or chronic conditions requiring continued monitoring and/or treatment. Due to the serious nature of these diseases/conditions, most Tennessee insurance companies will deny coverage to individuals with a medical history that includes one or more of these diseases/conditions.

"Medical records" are defined in TCA 63-2-101(c)(2) as "medical histories, records, reports and summaries, diagnoses, prognoses, records of treatment and medication ordered and given, x-ray and radiology interpretations, physical therapy charts and notes, and lab reports." Applicants for Medically Eligible status are not required to submit all the medical records they may have. Rather, they are required to submit a copy of a current medical record or portion of a medical record that documents the existence of the medical condition they have said that they have. A lab test may be sufficient in some circumstances. However, the lab test cannot be "anonymous"—it must be clearly identified as belonging to the person applying for Medically Eligible status.

Each of the methods above requires the applicant to include with the completed application all supporting documentation. Only complete applications accompanied by the required supporting documentation will be processed.

Eligibility for those children who qualify as Uninsured or as Medically Eligible will begin on the initial application date and will not reflect a break in coverage from the child's previous Medicaid coverage.

Medically Eligible TennCare Standard enrollees must renew their TennCare eligibility on the same schedule as other TennCare enrollees. Renewing TennCare eligibility means updating information on income, family size, access to insurance, etc. However, the medical criteria for

Medical Eligibility will not be verified annually for those who remain on the program without a break in coverage.

1. Effective date of eligibility

SSI eligibles: The date determined by the Social Security Administration in approving the individuals for SSI coverage.

All other Medicaid eligibles: The <u>date of the application</u>, or the <u>date of the qualifying event</u> (such as the date that a spend-down obligation is met), whichever is <u>later</u>.

The date of application for Medicaid is:

- The date a signed application form is received in the county DHS office. The "begin date" for Medicaid is the application date or the date all eligibility requirements are met, whichever is later (example: a spend down case who becomes eligible after the application date) or
- The date a faxed application is received at DHS. Eligibility begins either the date of the fax or the date all eligibility requirements are met, whichever is later.

There are two presumptive eligibility categories in TennCare Medicaid. One is for pregnant women, and the other is for women under age 65 who are uninsured or whose insurance does not cover treatment for breast or cervical cancer and who have been found by CDC to need treatment for these conditions. The effective date of eligibility in either category is the date an application is approved at the Department of Health or at any alternative sites chosen by the Department of Health.

Persons enrolling in TennCare in an open Medically Needy category get an automatic year of TennCare coverage.

All demonstration eligibles: For persons under age 19 whose Medicaid eligibility is ending and who meet the eligibility requirements for TennCare Standard either as Uninsured or as Medically Eligible, the date of eligibility will be the date of application and will reflect no break in coverage from the previous Medicaid segment.

2. Re-establishment of eligibility

Eligibility in all TennCare categories will have a "begin date" and an "end date". A person may remain on TennCare past her end date only if she reapplies and is determined to be eligible for a new period of eligibility. All TennCare enrollees must re-establish their ongoing eligibility for TennCare on at least an annual basis. Ex parte reviews conducted by DHS, Request for Information notices, and/or face-to-face meetings between the DHS worker and the enrollee are the means by which this is accomplished. Enrollees will be required to provide updated information on their employment, income, assets, family status and other pertinent issues.

The determination that an individual meets the medical criteria for Medical Eligibility for TennCare Standard will be reverified every two or three years. However, people who are Medically Eligible will still have to renew their TennCare coverage each year and provide updated information on residency, changes in income, and access to group health insurance.

Changes in income, family status or living circumstances (including address changes) that occur in the interim periods between "begin" and "end" dates of coverage must be reported by the

enrollee to her DHS worker within 30 days, in accordance with TCA 71-5-110. Failure to report such changes in a timely manner may result in termination from the program.

3. Rollover eligibility for individuals under age 19

If an enrollee under the age of 19 loses eligibility for TennCare Medicaid, he may apply for TennCare Standard and, if eligible, be enrolled in TennCare Standard without a break in coverage, unless the loss of eligibility is due to incarceration or non-resident status. (Persons who lose eligibility because they are incarcerated or who move permanently out-of-state are not eligible to continue on TennCare as "Medicaid Rollovers.") Enrollees who are children under the age of 19 moving from Medicaid to TennCare Standard will receive the same benefits as were included in their TennCare Medicaid benefit package. Thereafter, these enrollees must reestablish eligibility for TennCare Standard at announced intervals, which will occur at least within a 12 month period. Enrollees losing eligibility for TennCare Standard are provided, upon request, with Certificates of Creditable Coverage, as required under the Health Insurance Portability and Accountability Act (HIPAA). Persons who are denied TennCare Standard eligibility will receive timely notice of their denial and appeal rights.

Individuals who voluntarily terminate their TennCare coverage will also be provided with timely Certificates of Creditable Coverage.

4. Presumptive eligibility

Presumptive eligibility for pregnant women is conducted consistent with the standards and criteria followed by Tennessee Medicaid and in accordance with its approved Medicaid State Plan. Presumptively eligible pregnant women have 45 days to complete the full eligibility determination process. During the presumptive period, the woman is considered to be a "temporary" Medicaid enrollee; if she does not go to DHS and become eligible in a Medicaid category, she will not be permitted to stay on TennCare when her presumptive period ends.

There is no presumptive eligibility for children, except that children entering state custody are deemed "immediately eligible" for TennCare while their TennCare applications are being processed. Should the result of the eligibility determination process be that the children are not eligible for TennCare, DCS will reimburse TennCare Select for any dollars spent on these children's behalf.

There is also presumptive eligibility for certain uninsured women identified by a CDC (Centers for Disease Control and Prevention) site as requiring the need for treatment for breast or cervical cancer. Women who are under age 65, who are uninsured or whose insurance does not cover treatment for breast or cervical cancer, and who have been screened at a CDC site and determined to be in need of treatment for breast or cervical cancer may be determined to be presumptively eligible for Medicaid at the CDC site. They then go to their county DHS office for determination of eligibility beyond the 45-day presumptive period. Coverage in this category is limited to the period during which a woman requires treatment for the breast or cervical cancer. Coverage is provided to these women who would not otherwise be eligible for Medicaid.

5. Newborns

Newborns are added to the mother's TennCare Medicaid or TennCare Standard coverage/care effective on the date of birth. TennCare coverage is automatically granted to any infant born to a TennCare-eligible mother. Parents or family representatives must take steps to get the infant

enumerated for Social Security purposes, however, so that she will not fail the TennCare technical eligibility requirement that every enrollee has a valid Social Security Number.

For newborns, a hospital worker may provide to the mother, family member, or a family representative an SS5 Form to complete for the purpose of assigning a Social Security number to the newborn. The hospital worker or a DHS worker may assist in completing the SS5 Form, which is an application for a Social Security number/card. DHS is allowed to bypass the requirement that the newborn be enumerated if there is verification that an SS5 Form has been completed.

The MCO in which the mother is enrolled at the time of delivery will be responsible for the coverage and payment of all TennCare-covered services provided to the newborn, beginning at birth. Infants on TennCare Standard are automatically assessed for potential Medicaid eligibility at the mother's next annual visit at DHS for re-establishment of eligibility. New mothers may voluntarily present to their DHS worker for an assessment of Medicaid eligibility for their child at any time and, in fact, are encouraged to do so. Newborns of mothers who are enrolled as Medically Eligible must be assessed for their own eligibility category at the next time the family presents for recertification.

6. MEQC

The Department of Human Services presently conducts an alternative Medicaid Eligibility Quality Control (MEQC) Project for the Medicaid eligible population. The Bureau of TennCare conducts a separate alternative MEQC Project for the uninsured, uninsurable, and Medicaid "rollover" populations; this project was approved by CMS in August 2000. The Bureau has a contract with Dr. William F. Fox with the University of Tennessee's Center for Business and Economic Research (CBER) to do the separate alternative MEQC project.

CBER uses a random monthly sample selection methodology, with two six-month samples drawn per year. Two separate groups are sampled: active cases (those eligibles currently in the system) and negative cases (eligibles who are terminated and persons whose applications have been denied.) CBER gathers the data and conducts the surveys on both groups and forwards their results to TennCare for review by an "an external source". This means that TennCare's external source makes a decision as to whether a case is in error or not. Results from the review are resubmitted to CBER, which then produces a written report analyzing the findings and actions taken. A final report is submitted to the Bureau of TennCare. The external source at TennCare is staff from TennCare's Division of Quality Oversight who make MEQC error determinations. The external source is required to be staff independent of those responsible for eligibility policy operations (State Medicaid Manual, Part 7, Section 7005.1).

7. Special populations

This section describes how special populations are served within TennCare. The section is organized in two main subsections. The first includes a brief discussion of how special needs are met within mainstream managed care organizations, the behavioral health organizations, and the state's plan, TennCare Select. The second subsection addresses specific special needs populations within TennCare, including special needs children and children in state custody; Medicaid and Medicare dual eligibles; and aliens and refugees.

(a) Provisions for special populations within managed care models

The TennCare project includes a number of individuals with special health care needs. Most of these individuals are successfully served through the mainstream managed care organizations

(MCOs). Tennessee has developed and implemented rigorous plan participation standards to ensure that mainstream MCOs have networks and quality management programs necessary to adequately serve populations with special needs. These plan participation standards are described in the MCO contract.

Some special needs populations, including children in state custody, are enrolled in the state's self-insured health plan called TennCare Select. This plan was developed to address the needs of populations deemed more difficult to serve due to their health care needs, mobility, or geographic location.

TennCare enrollees receive necessary behavioral health services through contracted Behavioral Health Organizations (BHOs). Tennessee has developed standards for Behavioral Health Organizations similar to those for physical health MCOs. These standards are described in the BHO Contractor Risk Agreement.

(1) Mainstream Managed Care Organizations

TennCare enrollees receive their physical health services from contracted MCOs. MCOs are required to maintain adequate provider networks and must meet the geoacess standards outlined in the Special Terms and Conditions of the demonstration, as well as the following minimum guidelines:

- Networks must include specified safety net providers for specified safety net services;
- Networks must include at least one Center of Excellence for people with HIV/AIDS in each
 of the Grand Regions in which the MCO participates;
- Networks must include Centers of Excellence identified through the state's EPSDT program for treatment of children in state custody;
- Networks must include adequate numbers of physician specialists to meet the needs of the enrolled population;
- MCOs are encouraged to contract with Federally Qualified Health Centers. If an MCO chooses not to contract with FQHCs, it must demonstrate that its network is adequate without them to insure needed capacity and range of services for vulnerable populations;
- MCOs must contract with local health departments for EPSDT screenings, until the MCO can demonstrate that it is able to meet the EPSDT screening goals without these providers.

MCOs must also maintain appropriate case management systems to ensure that enrollees receive all necessary services on a timely basis.

(2) TennCare Select

In 2001, the state developed TennCare Select, a self-insured health plan administered for the state by Volunteer State Health Plan. TennCare Select currently serves the following populations:

- Children who are eligible for Supplemental Security Income;
- Children in state custody and children leaving state custody;
- Children in an institutional eligibility category (meaning eligible for care in a Nursing Facility or Intermediate Care Facility for the Mentally Retarded or an alternative to long-term care such as a Home and Community Based Services waiver):
- Enrollees temporarily residing out-of-state;
- Enrollees living in areas where there is insufficient MCO capacity to serve them.

TennCare Select also functions as the back-up plan should one of the MCOs have to leave the TennCare project unexpectedly. The state reserves the right to add groups to TennCare Select as needed.

All TennCare Select members are assigned to a Primary Care Provider (PCP) who is responsible for providing or arranging for the provision of necessary health care services. TennCare Select members are not required to get referrals from the PCPs for behavioral health services.

(3) Behavioral Health Organizations

Since 1996, TennCare enrollees have received behavioral health services through the TennCare Partners program. Under the Partners program, contracted behavioral health organizations provide covered behavioral health services. There are presently two BHOs. Behavioral health pharmacy services continue to be carved out and provided through the state's pharmacy program.

Contracts with MCOs and BHOs have been revised to be more specific regarding which services are to be covered by which entity and what mechanisms must be in place for MCO/BHO coordination.

As with the MCOs, the state requires the BHOs to meet certain minimum requirements to ensure that enrollees have appropriate and timely access to services. These requirements are contained within the BHO Contractor Risk Agreement.

Should one of the BHOs leave the TennCare project for any reason, the state will implement a contingency plan which will involve moving that BHO's members to the remaining BHO if the remaining BHO has adequate capacity and adequate financial reserves to accept the new members. Should the capacity or financial reserves of the remaining BHO not be adequate, the state would have no choice but to return to a modified fee-for-service arrangement in those areas of the state where such an arrangement is the only option. The state presented a proposed Emergency Plan to CMS in the spring of 2000 that outlined steps to be taken should it be necessary to return to such an arrangement because of the unexpected departure of one of the managed care entities. This plan, which was approved by CMS, will be used by the state if such an arrangement is necessary for the BHO project.

(b) Special needs children

(1) EPSDT services

EPSDT services are available for special needs children who are Medicaid-eligible, just as they are for other Medicaid-eligible children.

(2) Children in state custody

All TennCare-eligible children in state custody (other than those living in Youth Development Centers) are enrolled in TennCare Select for physical health services and care coordination. Children who leave state custody and who continue to be TennCare eligible remain in TennCare Select for a period of time to assure a smooth transition of care. Behavioral health services are provided by a BHO. In addition, children in or at risk of coming into state custody and who continue to be TennCare-eligible receive specialized services managed by the Department of Children's Services. For children at risk of custody, these services include targeted case management. For children in custody, these services include targeted case management and

the treatment components of residential care. Each child is assigned a TennCare Select PCP responsible for coordinating health and behavioral health care services among all care providers. These PCPs are part of a Best Practice Network (BPN), which is discussed in more detail in Part 4.

(c) Persons with Medicare

Medicaid/Medicare enrollees ("dual eligibles") receive services through a separate Section 1915(b) waiver. Their service package is identical to that offered under the TennCare demonstration. Individuals eligible for Medicaid and Medicare will continue to receive all of their pharmacy benefits directly from the state through December 31, 2005, after which time Medicare Part D will provide coverage for the majority of their pharmacy benefits.

The interaction between TennCare eligibility and benefits for persons with Medicare is shown in Attachment C. It should be pointed out that persons with opportunities to buy Medicare (Part A, Part B, and/or Part D as of January 1, 2006) must purchase this coverage according to the policies of the Medicare program.

(d) Aliens and refugees

Legal aliens and refugees continue to be eligible for TennCare as long as they meet Medicaid or TennCare Standard eligibility criteria, and are enrolled in MCOs and BHOs in the same manner as all other TennCare enrollees. Emergency services for undocumented aliens continue to be provided as federally mandated. Undocumented aliens are assigned to an MCO for the length of time of their emergency.

The state has taken a number of steps to ensure that TennCare is accessible for individuals who may not be English-proficient. All written TennCare educational materials and all enrollee notices have been translated into Spanish. All TennCare educational materials and enrollee notices are mailed with information providing a special telephone number through the TennCare Advocacy Program (formerly the TennCare Consumer Advocacy Line) for enrollees who speak Bosnian, Arabic, Somali, Vietnamese, and two dialects of Kurdish (Sorani and Badinani). MCOs and BHOs are required to have their member handbooks and vital documents available in Spanish. Contractors are required to provide appropriate interpretation services to assist enrollees with understanding the handbooks or vital documents. In addition, TennCare works with local organizations that serve the refugee populations, including those providing telephone translation services. TennCare contractors are responsible for assuring the provision of on-site language assistance for enrollees when necessary.

In addition, as part of the administrative appeals and hearing process, translators and interpreters are provided for all TennCare enrollees who need language assistance, at no cost to the enrollee. Attachments to the letter which is sent to enrollees outlining their appeal rights include a telephone number where they can get assistance in completing the appeal forms, as well as information on how to access free or low cost legal representation, and information on locating translators and/or interpreters.

8. Procedures for accommodating persons with other disabilities and limited English proficiency

In the spring of 2002, the Bureau formed an advocates' task force. This group has been meeting regularly since then to discuss advocacy/outreach issues and to develop materials to assist enrollees with special circumstances. This task force has developed public service

announcements, flyers, and other items for use in making sure that people understand the rules regarding the TennCare project.

(a) For individuals with Limited English Proficiency (LEP):

Both the TennCare Bureau and the Department of Human Services have made a number of provisions to assist individuals with LEP as they navigate the disenrollment and/or application process for TennCare eligibility.

Both agencies have applications available in English and Spanish. In addition, TennCare and DHS mail notices printed in English and Spanish. An insert in each mailing provides a toll-free phone number that individuals may call for assistance in translation. These inserts have this information in Arabic, Somali, Kurdish-Badinani, Kurdish-Sorani, Bosnian, and Vietnamese. In addition, all notices contain the number of the Family Assistance Service Center (formerly, the TennCare Information Line); through that number, a connection can be made with the AT&T Language Line for translation services, if necessary.

The TennCare Bureau also maintains a contract with the Crisis Intervention Center, an advocacy group, which operates the TennCare Advocacy Program (formerly the Consumer Advocacy Line). The TennCare Advocacy Program provides translation services to TennCare enrollees and applicants and can also direct enrollees and applicants to local community translation resources.

The Department of Human Services also provides translation services, through bi-lingual staff, a contract with the AT&T Language Line, and through contracted and volunteer community translators.

Both the TennCare Bureau and DHS maintain access to text telephones for the hearing impaired, and DHS also has sign language interpreters and readers for the visually impaired on contract. Finally, in order to assist individuals who do not read with the Disenrollment Process, the TennCare Bureau has developed a special green flag for the envelopes that it is using to send RFI notices to TennCare enrollees and, in PSAs and other written and oral communications, directs enrollees to look for the green letters on the envelope and take the material to someone who can assist them in understanding the material contained.

(b) People with physical and other disabilities

The following strategies are in place to assist clients with a wide range of disabling conditions that might make the disenrollment or application process more difficult.

DHS has been performing eligibility determinations for Medicaid, Food Stamps, and its Families First program for many years. The Department has a lengthy list of accommodations that it has made and will continue to make available to the TennCare population. These accommodations include:

- Letting the enrollee/applicant designate a third party to represent her during the eligibility determination process;
- Conducting the interview with an individual over the phone;
- Conducting the interview at an alternative site that is easier for the enrollee/applicant to access:
- Conducting the interview outside of normal working hours;
- In extreme cases, conducting the interview in the enrollee's home.

C. Enrollment Process

Overview

Managed Care Organizations (MCOs) are Health Maintenance Organizations (HMOs) under contract with the Bureau of TennCare to serve TennCare Medicaid and Standard enrollees. MCOs provide a comprehensive range of physical health care services to TennCare enrollees through a network of health care providers. Information about eligibility and enrollment, the MCOs, and covered services may be obtained by calling the DHS Family Assistance Service Center's toll-free number (1-866-311-4287), or by accessing the Bureau of TennCare's website (www.Tennessee.gov/TennCare).

The Bureau of TennCare contracts with 8 Managed Care Organizations (MCOs) to provide services to enrollees. MCOs provide all covered services (other than behavioral health and long-term care) to TennCare enrollees and to Medicaid/Medicare dual eligibles enrolled in the state's 1915(b) demonstration project. BHOs provide all covered behavioral health services, except for pharmacy, to TennCare enrollees and to Medicaid/Medicare dual eligibles enrolled in the state's 1915(b) demonstration project. A list of the current MCOs and BHOs is contained in Attachment D.

TennCare Standard enrollees receive a benefit package that includes a comprehensive array of covered services. The package is designed to be similar to a standard HMO benefit package. TennCare Standard members are enrolled in MCOs for their physical health care and BHOs for their mental health and substance abuse treatment needs.

TennCare Select is a state-organized health plan that is administered by Volunteer State Health Plan. TennCare Select is available for certain groups of special needs children, such as SSI children and children who are in institutional placements or alternatives to institutional placements. Parent or legal guardians of these children can "opt out" of TennCare Select during change periods if they choose. TennCare-eligible children in state custody are enrolled in TennCare Select. In addition, TennCare Select serves as the health plan for TennCare enrollees who are temporarily out-of-state.

TennCare Select further functions as the "safety net" health plan should an MCO exit the TennCare project unexpectedly. In such a situation, the exiting plan's members will be assigned to TennCare Select. Such assignments are temporary, and enrollees are transitioned to another MCO as soon as one becomes available in their geographic area. The Bureau gives notice to these enrollees of their temporary assignment to TennCare Select and instructs them in the procedures for accessing covered health care services. TennCare Select is not open for voluntary selection on the part of enrollees.

Behavioral Health Organizations (BHOs) are prepaid health care plans that provide behavioral health services only. The program for delivering covered behavioral and substance abuse services is known as the "Partners" program.

1. Procedures for enrollment into MCOs

At the time the application for TennCare is completed, the applicant selects an MCO from among those available in her area. All family members in the same case must enroll in the same MCO, except for children eligible to enroll in TennCare Select. Individuals who are returning to TennCare after a lapse in eligibility will be re-assigned to their former MCO if the lapse in eligibility has been for less than a year. This assignment is an initial assignment only; members are given 45 days after their re-enrollment in TennCare to change MCOs if they wish.

If the applicant is subsequently approved for TennCare Medicaid or TennCare Standard, enrollment in the MCO will be effective on the same day that coverage in the program becomes effective.

Applicants who fail to select an MCO at their DHS interview are assigned to one that is available in the area in which they live. MCOs issue identification cards to enrollees, and such cards are used to access services from MCO network providers. Once enrolled, TennCare eligibles have 45 days to change MCOs if they are dissatisfied with their MCO for any reason. After the 45 day change period, enrollees can only change MCOs based on proof of hardship criteria (see Attachment E) or once during the annual reverification visit. TennCare also permits changes to put all family members in the same MCO, unless one of the family members is in TennCare Select. The TennCare Solutions Unit within the Bureau reviews and issues decisions on MCO change requests related to medical or service access issues.

Each MCO is responsible for providing a Bureau-approved Member Handbook to each enrollee immediately upon being notified of the enrollee's eligibility.

2. Procedures for enrollment into BHOs

TennCare Medicaid and TennCare Standard enrollees are automatically enrolled in the BHO which is paired with the MCO to which they belong. The BHO also issues identification cards to its enrollees.

3. Procedures for enrollment into TennCare Select

The Department of Children's Services determines Medicaid eligibility for children in custody, and the Social Security Administration determines eligibility for children who qualify for SSI benefits. Eligibility files are transferred to TennCare Select from these agencies, and identification cards are issued. Other groups are enrolled in TennCare Select when there is a need, such as when there is inadequate MCO capacity in an area.

4. Procedures for changing MCOs/BHOs

Enrollees are given their choice of health plans when possible. Once enrolled, the new enrollee may change MCOs (if an alternate plan is available) within the first 45 days of enrollment. Thereafter, the enrollee must remain in the assigned MCO until he is given an opportunity to change MCOs during his next recertification interview. Only one change is permitted per year unless the enrollee moves out of the area served by his plan or a change is approved through the resolution of an enrollee appeal.

When an enrollee files an appeal to change his MCO, the request is sent to the TennCare Solutions Unit (TSU). TSU reviews the appeal and request to change MCOs against the six "hardship criteria" (see Attachment E); all criteria must be met for the MCO to be changed. If criteria are met, TSU has the capability to key the change online. If the six criteria are not met, the appeal is scheduled for hearing.

Enrollees, after going through the appeal procedure and obtaining the approval of the TennCare Bureau, may be permitted to change enrollment to a different health plan. In the event an enrollee changes plans, the enrollee's medical care will be the responsibility of the original health plan until the date that the new MCO assignment is effective.

An enrollee must change MCOs if she moves outside the MCO's Community Service Area (CSA) and that MCO does not operate in the enrollee's new area of residence. Until the

enrollee selects or is assigned to a new MCO, her medical care is the responsibility of the original MCO.

Enrollees will be given the opportunity to select a new health plan if their MCO withdraws from participation in TennCare and is no longer available. If a selection is not made timely, the enrollee will be assigned to an available MCO operating in the CSA. The enrollee will have 45 days afterward to change MCOs if he wishes.

Families are encouraged to be in the same health plan when feasible or possible. If a family member is in an MCO different from the other family members, she may request an MCO change. These requests are submitted in writing to the Family Assistance Service Center (formerly the TennCare Information Line) or to the TennCare Legislative Response Unit. (See Attachment F for telephone numbers.) The head of household or guardian must submit the names of all persons and their Social Security numbers with a request to change MCOs. The change is made online if the requested MCO is open and is in the enrollee's CSA.

5. Procedures for annual notification of members

In keeping with the notice requirements outlined in the federal managed care regulations at 42 CFR 438.10(f), the state will provide a standard insert to go in its mailings to enrollees regarding enrollment matters. Enrollees will receive this information at least once a year.

The insert we currently use called "Do You Need Special Help?" offers information regarding various language lines and help lines that are available to enrollees. We plan to amend this notification to include information on the topics in 42 CFR 438.10(f). Some of this information will be identification of web-based information sources. All Tennessee public libraries offer free access to the internet for those wishing to research these sources in more detail.

D. Marketing and Outreach Strategy

1. Marketing activities and restrictions

Marketing guidelines are included in Managed Care Organization contracts. Key points are summarized below.

Managed care organizations (MCOs) must submit a detailed marketing plan, all marketing materials and a description of marketing activities to TennCare for review and approval prior to implementation or use. All written marketing materials must be worded at a reading level that does not exceed sixth grade and must be printed with a minimum font size of 12 points. Materials must be made available in English and Spanish and in the language of any other Limited English Proficiency group identified by TennCare that constitutes five percent of the TennCare population or 1,000 enrollees, whichever is less.

Written materials must be made available in alternative formats or appropriate interpretation services must be provided for persons with special needs.

MCOs are permitted to distribute approved material through mass media and through general activities that benefit the entire community, such as health fairs. Telephone calls, mailings or home visits to current enrollees are permitted only for the purpose of educating current enrollees about services offered by the MCO.

The following activities are prohibited:

• Use of materials or activities that mislead, confuse, defraud, or are unfair;

- Use of overly aggressive solicitation;
- Gifts and offers of material or financial gain as incentives to enroll;
- Compensation arrangements with marketing personnel that tie compensation to the number of persons enrolled;
- · Direct solicitation of prospective enrollees;
- Use of independent marketing agents.

2. Monitoring

The primary focus of monitoring activities is on preventing potential marketing abuses by requiring the prior review and approval of detailed marketing plans and all marketing materials. In the event that marketing abuses are suspected or reported, additional monitoring activities may include member surveys, random audits, or undercover observation of marketing activities. Each of these activities is described below.

(a) Review and approval of marketing plans and activities

As set forth in the Contractor Risk Agreement, MCOs must submit detailed descriptions of all proposed marketing activities as well as copies of all marketing materials to be used. These include: all policies and marketing manuals; advertisement copy; brochures; posters; fact sheets; video tapes; story boards for production of videos; audio tapes; newsletters; telemarketing scripts; and any other forms of advertisement as well as other forms of public contact such as participation in health fairs.

The marketing plans and materials are reviewed to ensure that proposed activities are permitted under state and federal marketing guidelines. TennCare will approve, deny or return the plan with comments within 15 days. Once approved marketing materials have been produced, copies of the final product must be submitted to TennCare. TDMHDD will review BHO marketing materials.

(b) Member surveys

If marketing abuses are identified or suspected, targeted member surveys will be conducted. The surveys may be designed to focus on a specific MCO or BHO, or may be conducted across all participating MCOs. The surveys may be conducted by telephone, mail or a combination, depending on the nature of the marketing problems being investigated.

Examples of questions that could be included in marketing surveys are:

- Has any MCO called you or sent you materials in the mail? If yes, did you request a call or materials in advance?
- Did you speak with any MCO representatives prior to enrolling in TennCare? If yes, where did you speak with the representative?
- Was the information you received helpful?
- Was the MCO representative polite?
- Did any MCO offer you a gift if you enrolled?

Results will be summarized and reviewed by the TennCare staff, who will determine the appropriate response, including further audits or investigations, written warnings to the MCO, or initiation of corrective action.

(c) Random audits

If TennCare believes that violations of the marketing guidelines have occurred, further audits or surveys may be conducted. The type of audit or survey will depend on the nature of the suspected problem. For example, unannounced visits to health fairs or other MCO marketing sites can be implemented to observe interaction between marketing representatives and potential enrollees, obtain samples of marketing materials being distributed, and conduct brief interviews with potential enrollees to elicit feedback on the marketing activities and information received.

(d) Corrective action

TennCare has a wide range of remedies available in the event of marketing abuses. The following specific remedies are included in the Contract:

- Revocation of previously approved marketing activities;
- Imposition of financial sanctions including liquidated damages;
- Suspension of enrollment;
- Disenrollment of MCO enrollees; or
- Limitations of the MCO's service area.

MCOs are required to develop and implement corrective actions to remedy the marketing problem(s). Any or all of the above sanctions may be imposed until such time as the state is satisfied that the problem has been resolved.

Part Three: Benefits

A. Benefit Packages

Overview

Summaries of physical health benefits and behavioral health benefits included in TennCare's benefit packages are presented in Attachments G.

Effective August 1, 2005, TennCare implemented benefit changes which limited and/or eliminated certain services for different groups of TennCare members. Once the state has secured approval of its pending benefit changes, which will limit and/or eliminate additional services, the Operational Protocol will be updated accordingly.

Benefit Packages

Dependent upon the category of TennCare for which they qualify, members will receive benefits from one of four Benefit Packages described below. Only the services that are changing (becoming limited and/or eliminated for some or all populations based on amendments to the TennCare demonstration projected) are included in this description. Tennessee has received authority to implement additional benefit changes but has not yet implemented this authority.

(a) Benefit Package A

For TennCare Standard and Medicaid individuals under the age of 21:

Benefit	
Prescription Medication	As medically necessary
Over-the-Counter Medication	Covered
Dental Services	Covered
Sitter Services*	Covered
Convalescent Care*	Covered
Nursing Home Bed Holds	Covered
Methadone Clinic Services	Covered

^{*}The State has received authority to eliminate sitter services and convalescent care for TennCare enrollees under are 21, but has not yet implemented the authority. Tennessee intends to implement this authority on or after January 1, 2006.

(b) Benefit Package B

For non-institutionalized TennCare Medicaid adults in a mandatory or optional Medicaid category:

Benefit	
Prescription Medication	5 prescription/month (2 brand name, 3 generic)
Over-the-Counter Medication	Not Covered (with the exception of pre-natal vitamins)
Dental Services	Not Covered
Sitter Services	Not Covered
Convalescent Care	Not Covered
Nursing Home Bed Holds	Not Covered
Methadone Clinic Services	Not Covered
Inpatient and Outpatient	Covered as medically necessary

Substance Abuse Services*	

^{*} The State has received authority to impose a \$30,000 lifetime limit on substance abuse services for adult SPMI TennCare enrollees. The State has not yet implemented this authority, but intends to do so on or after January 1, 2006.

(c) Benefit Package C

For institutionalized adults age 21 and older in a mandatory or optional Medicaid category:

Benefit	
Prescription Medication	As medically necessary
Over-the-Counter Medication	Not Covered (with the exception of pre-natal
	vitamins prescribed for a pregnant enrollees)
Dental Services	Not Covered
Sitter Services	Not Covered
Convalescent Care	Not Covered
Nursing Home Bed Holds	Not Covered
Methadone Clinic Services	Not Covered
Inpatient and Outpatient	Covered as medically necessary
Substance Abuse Services*	

^{*} The State has received authority to impose a \$30,000 lifetime limit on substance abuse services for adult SPMI TennCare enrollees. The State has not yet implemented this authority, but intends to do so on or after January 1, 2006.

(d) Benefit Package D

For TennCare Standard adults age 21 and older

Benefit	
Prescription Medication	Not Covered
Over-the-Counter Medication	Not Covered
Dental Services	Not Covered
Sitter Services	Not Covered
Convalescent Care	Not Covered
Nursing Home Bed Holds	Not Covered
Methadone Clinic Services	Not Covered
Inpatient and Outpatient	Covered as medically necessary
Substance Abuse Services*	

^{*} The State has received authority to impose a \$30,000 lifetime limit on substance abuse services for adult SPMI TennCare enrollees. The State has not yet implemented this authority, but intends to do so on or after January 1, 2006.

B. Cost Sharing

Overview

TennCare Standard enrollees with income above 100% of poverty must pay a share of the cost of their health care services. TennCare Standard cost sharing occurs in two ways: monthly premiums, and copays for specific services. Pharmacy copays shall apply to TennCare Standard enrollees as well as certain non-institutional Medicaid adults. This section describes premiums and co-payments under the TennCare project.

1. Premiums

Premiums are set on a sliding scale basis depending on family size and income. They are calculated by the DHS ACCENT system using information provided by applicants and verified during the interview at DHS. The premiums for the TennCare Standard population have been established based on the current TennCare premium schedule; that is, participants pay a percentage of the cost of the premium applicable to their income group. Each year, premiums may increase by an amount not to exceed the percentage of the aggregate per capita budget increase necessary to sustain the managed care portion of the TennCare project. Premiums are increased each year at the same time the poverty level is updated. Individuals can always appeal their premium amounts if they believe these are incorrect.

Current TennCare Premiums are shown in Table 7.

Table 7
TennCare Premium Chart

Individual Premium	\$0	\$20.00	\$35.00	\$100.00	\$150.00
Family Premium	\$0	\$40.00	\$70.00	\$250.00	\$375.00
Percentage of Poverty	0% - 99%	100% - 149%	150% - 199%	200% - 249%	250% - 299%
Family Size	Monthly Income	Monthly Income	Monthly Income	Monthly Income	Monthly Income
1	\$0 - \$797	\$798 - \$1,196	\$1,197 - \$1,594	\$1,595 - \$1,993	\$1,994 - \$2,392
2	\$0 - \$1,069	\$1,070 - \$1,603	\$1,604 - \$2,138	\$2,139 - \$2,672	\$2,673 - \$3,207
3	\$0 - \$1,340	\$1,341 - \$2,011	\$2,012 - \$2,681	\$2,682 - \$3,352	\$3,353 - \$4,022
4	\$0 - \$1,612	\$1,613 - \$2,418	\$2,419 - \$3,224	\$3,225 - \$4,031	\$4,032 - \$4,837
5	\$0 - \$1,884	\$1,885 - \$2,826	\$2,827 - \$3,768	\$3,769 - \$4,710	\$4,711 - \$5,652
6	\$0 - \$2,155	\$2,156 - \$3,233	\$3,234 - \$4,311	\$4,312 - \$5,389	\$5,390 - \$6,467
7	\$0 - \$2,427	\$2,428 - \$3,641	\$3,642 - \$4,854	\$4,855 - \$6,068	\$6,069 - \$7,282
8	\$0 - \$2,699	\$2,700 - \$4,048	\$4,049 - \$5,398	\$5,399 - \$6,747	\$6,748 - \$8,097
9	\$0 - \$2,970	\$2,971 - \$4,456	\$4,457 - \$5,941	\$5,942 - \$7,427	\$7,428 - \$8,912
10	\$0 - \$3,242	\$3,243 - \$4,863	\$4,864 - \$6,484	\$6,485 - \$8,106	\$8,107 - \$9,727
For each family member over 10, add per month	\$0 - \$272	\$272 - \$408	\$408 - \$544	\$544 - \$679	\$679 - 815

Individual Premium	\$200.00	\$250.00	\$350.00	\$450.00	\$550.00
Family Premium	\$500.00	\$625.00	\$875.00	\$1,125.00	\$1,375.00
Percentage of Poverty	300% - 349%	350% - 399%	400% - 499%	500% - 599%	600% - Over
Family Size	Monthly Income	Monthly Income	Monthly Income	Monthly Income	Monthly Income
1	\$2,393 - \$2,791	\$2,792 - \$3,189	\$3,190 - \$3,987	\$3,988 - \$4,784	\$4,785 – Over
2	\$3,208 - \$3,742	\$3,743 - \$4,276	\$4,277 - \$5,345	\$5,346 - \$6,414	\$6,415 – Over
3	\$4,023 - \$4,692	\$4,693 - \$5,363	\$5,364 - \$6,704	\$6,705 - \$8,044	\$8,045 - Over
4	\$4,838 - \$5,643	\$5,644 - \$6,450	\$6,451 - \$8,062	\$8,063 - \$9,674	\$9,675 - Over
5	\$5,653 - \$6,594	\$6,595 - \$7,536	\$7,537 - \$9,420	\$9,421 - \$11,304	\$11,305 - Over
6	\$6,468 - \$7,545	\$7,546 - \$8,623	\$8,624 - \$10,779	\$10,780 - \$12,934	\$12,935 - Over
7	\$7,283 - \$8,496	\$8,497 - \$9,709	\$9,710 - \$12,137	\$12,138 - \$14,564	\$14,565 - Over
8	\$8,098 - \$9,447	\$9,448 - \$10,796	\$10,797 - \$13,495	\$13,496- \$16,194	\$16,195 - Over
9	\$8,913 - \$10,397	\$10,398 - \$11,883	\$11,884 - \$14,854	\$14,855 - \$17,824	\$17,825 - Over
10	\$9,728 - \$11,348	\$11,349 - \$12,969	\$12,970 - \$16,212	\$16,213 - \$19,454	\$19,455 - Over
For each family					
member over 10, add per month	\$815 - \$951	\$951 - \$1087	\$1087 - \$1358	\$1358 - \$1630	\$1630 - Over

(a) Premium calculation

Premiums are calculated by Department of Human Services (DHS) workers at the applicant's interview.

If approved, a letter will be generated and sent from TennCare stating that the person has met TennCare Standard eligibility requirements effective on a certain date and premiums will be billed accordingly.

For those persons already enrolled in TennCare Standard whose eligibility is being reviewed during a renewal visit, the current billing/dunning process will apply. The DHS worker will not have a role in the premium process since the enrollee is already a TennCare member and is aware of the premium responsibilities. If the premium amount is changing due to change in income or family size, a notice sent from TennCare will inform the enrollee of the new premium amount.

(b) Collection and posting of premiums

TennCare issues a premium statement on a monthly basis. Payment is due by the first of the month and must be made by check or money order. All payments must be mailed to the TennCare Bureau at the address on the premium statement.

(c) Late payment procedures

Enrollees are given a 60-day "grace period" for late payments. If payment has not been received by the 30th day, TennCare sends a late premium notice informing the enrollee that benefits will be terminated if payment is not received. The notice includes information on the amount now due (the past and current months' premium).

If payment has not been received by the 60th day, a termination notice is sent informing the enrollee that eligibility will end in thirty (30) days. The notice includes information on how to appeal if the enrollee believes the termination is in error, as well as information on how to re-apply. Enrollees terminated for failure to pay premiums can only re-apply for and meet eligibility criteria as Medicaid eligibles. Premium arrearages in effect as of July 1, 2002, will not affect an enrollee's TennCare Standard eligibility going forward. TennCare does not allow payment plans.

If an enrollee files an appeal and is found to have been terminated in error, the enrollee will be reinstated with no break in coverage.

(d) Income and premium changes

Enrollees must report any changes in income and family size at the time such changes occur. Income changes must be reported to the enrollee's DHS worker. Enrollees must provide a completed employer statement showing the new income. Self-employed enrollees must provide appropriate proof of income changes, such as the most recent quarterly tax statement filed with the IRS. Details regarding documents to be supplied to DHS and requirements regarding reporting of changes in information are provided in TCA 71-5-110.

The DHS worker will enter the new income information, and ACCENT (the DHS system) will recalculate the premium obligation. Changes will be effective the first day of the

month following the month in which the change is reported. Changes will not be made on a retroactive basis.

Enrollees are also required to report any changes in family size. Changes must be reported to the enrollee's DHS worker. Appropriate documentation is required, as follows:

- Divorce or separation: copy of the divorce or separation papers
- Marriage: copy of marriage license
- Adoption or custodial arrangement for child: copy of the adoption or guardianship papers
- Death: copy of death certificate, funeral program, or newspaper announcement
- Removal of child (under age 19) from a case: proof the child has married or had a child

Individuals not already eligible for TennCare can be added for purpose of determining family size. Changes in family size may affect premium obligations. Individuals seeking TennCare coverage must complete the application and eligibility determination process.

TennCare makes an exception for newborns. Newborns should be reported to DHS. If one of the parents is enrolled in TennCare at the time of birth, the effective date of coverage for the newborn will be the date of birth. Parents or family representatives should proceed immediately with enumeration of the infant for Social Security Number purposes. Newborns of Medically Eligibles will be required to establish eligibility in their own category at the next family renewal interview.

2. Copays other than pharmacy copays

Copays for TennCare Standard enrollees with incomes at or above 100% of poverty are similar to commercial copays and are shown in Table 8. To encourage good preventive health habits, there are no copays for preventive care visits such as well child visits, immunizations, check-ups, pap smears, prostate examinations, and mammograms.

Table 8
Co-payment schedules for TennCare Standard
Non-pharmacy Services

Poverty Level	Co-payn	nent Amounts
0%-99%	\$0.00	
100% - 199%	\$25.00	Hospital Emergency Room (waived if admitted)
	\$5.00	Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care
	\$15.00	Physician Specialists (including Psychiatrists)
	\$100.00	Inpatient Hospital Admission
200% and above	\$50.00	Hospital Emergency Room (waived if admitted)
	\$10.00	Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care
	\$25.00	Physician Specialists (including Psychiatrists)
	\$200.00	Inpatient Hospital Admission

Medicaid eligibles are exempt from non-pharmacy copays. Preventive services are exempt from copay obligations.

Effective August 1, 2005, there are no deductibles or annual out-of-pocket (OOP) maximums which apply to persons with copay obligations. This means that an enrollee is required to pay all copays in a given calendar year, with no limit.

Copays are due at the time of service and are collected by the health care provider.

3. Pharmacy Copays

Pharmacy copays apply to TennCare Standard children whose family income is at or above 100% of the federal poverty level, as well as non-institutionalized Medicaid adults in the TennCare project.

The pharmacy benefits manager (PBM) processes online, point-of-service (POS) pharmacy claims and reduces the reimbursement to the pharmacist by the appropriate copay amount. The dispensing pharmacist collects the appropriate co-payment from the member.

Effective August 1, 2005, the Pharmacy Copay amounts are as follows:

Generic \$0 Brand Name \$3

Pharmacy co-payments do not apply to family planning services, emergency services, pregnant women, institutionalized enrollees, or enrollees receiving Hospice care.

There are no annual out-of-pocket (OOP) maximums which apply to pharmacy co-payments. This means that an enrollee is required to pay all pharmacy co-pays in a given calendar year, with no limits.

Part Four: Service Delivery

A. Organization of Managed Care Networks

1. Grand regions and "regions"

Grand regions are the three geographical regions into which the state of Tennessee is divided: East Tennessee, Middle Tennessee, and West Tennessee. MCOs wishing to participate in TennCare must be regionally based—that is, they must cover one of the three geographical regions. Generally, they are not permitted to cover an area that is smaller than one of the three grand regions. They are permitted to operate in more than one grand region only at the discretion of TennCare.

The three grand regions consist of the following regions, or Community Service Areas (CSAs):

- East Grand Region: First Tennessee, East Tennessee, Knox, Southeast Tennessee, and Hamilton Regions
- **Middle Grand Region:** Upper Cumberland, Mid Cumberland, Davidson, and South Central Regions
- West Grand Region: Northwest, Southwest, and Shelby Regions

"Regions" are defined geographical areas that encompass a cluster of adjoining counties. They are also called Community Service Areas (CSAs). There are 12 regions in Tennessee, and they are made up of the following counties:

East Grand Region

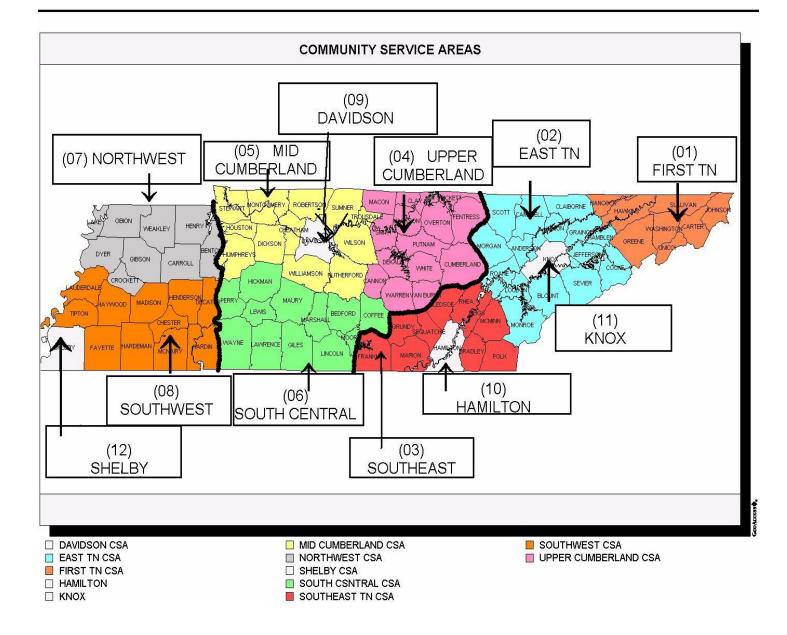
- First Tennessee Region: Hancock, Hawkins, Sullivan, Greene, Washington, Unicoi, Carter, and Johnson Counties
- East Tennessee Region: Scott, Campbell, Claiborne, Morgan, Anderson, Union, Grainger, Hamblen, Jefferson, Cocke, Sevier, Blount, Monroe, Loudon, and Roane Counties
- Knox County Region: Knox County
- **Southeast Tennessee Region:** Franklin, Grundy, Sequatchie, Bledsoe, Rhea, Meigs, McMinn, Polk, Bradley, and Marion Counties
- Hamilton County Region: Hamilton County

Middle Grand Region

- **Upper Cumberland Region:** Macon, Clay, Pickett, Smith, Jackson, Overton, Fentress, Dekalb, Putnam, Cumberland, White, Cannon, Warren, and Van Buren Counties
- **Mid Cumberland Region:** Stewart, Montgomery, Robertson, Sumner, Trousdale, Houston, Dickson, Cheatham, Wilson, Humphreys, Williamson, and Rutherford Counties
- Davidson County Region: Davidson County
- **South Central Region:** Perry, Hickman, Maury, Marshall, Bedford, Coffee, Wayne, Lewis, Lawrence, Giles, Lincoln and Moore Counties

West Grand Region

- Northwest Region: Lake, Obion, Weakley, Henry, Dyer, Crockett, Gibson, Carroll, and Benton Counties
- **Southwest Region:** Lauderdale, Haywood, Madison, Henderson, Decatur, Tipton, Fayette, Hardeman, Hardin, Chester, and McNairy Counties
- Shelby County Region: Shelby County



2. Selection and contracting process

In order for an MCO to be selected for participation in the TennCare project, it must meet all of the qualifications established in the TennCare Contractor Risk Agreement. Included in these qualifications are the following:

- Appropriate licensure as an HMO by the Tennessee Department of Commerce and Insurance:
- Demonstration of adequate financial capacity to take on risk for all contracted services and enrollees.
- Demonstration of an adequate provider network to deliver all contracted services to all enrollees in the plan in accordance with time/distance/location/patient volume standards established by TennCare;
- Demonstration of ability to offer electronic billing to providers, to comply with prompt pay processing requirements, and to use standard billing forms and formats as required by TennCare and TDCI;

- Demonstration of ability to adhere to all quality health standards, including preventive health standards, established by TennCare;
- Demonstration of ability to report provider related data using a uniform provider number, as established by TennCare;

New or start-up MCOs normally begin operating at the beginning of a TennCare contract period. For new MCOs, the contracting process begins when the prospective MCO notifies the state of its interest in participating in TennCare. At such time as the state decides to bring new MCOs into the project, the state may issue a Request for Responses (RFR) outlining the specific capabilities it expects the MCO to demonstrate. Copies of the RFR will be sent to all MCOs having provided a written notification to the state of their interest in coming into the TennCare project.

Responses to the RFR will be evaluated objectively by the state. MCOs which are determined to meet the criteria set out in the RFR will be offered an opportunity to enter into a contract with TennCare. (TennCare must have a contract with new MCOs well in advance of the start-up date in order to share information to test information systems and perform other key assessments of the MCO's readiness to take on members.) Prospective MCOs will be provided with a series of milestones they must meet in order to begin accepting enrollees in the project at a date certain in the future. The contract will be subject to termination by the state if the MCO is unable to demonstrate sufficient progress in its ability to meet these milestones.

For existing MCOs, the contracting process is an ongoing one. Contracts are amended, renegotiated, and/or terminated in accordance with the terms outlined in the contract.

3. Benefit packages

Both physical health services and behavioral health services are covered under TennCare. The list of these services is found in Attachment G.

4. Network requirements

Network requirements are contained in the Special Terms and Conditions for Access (see Attachment H).

5. Mailing of identification cards

MCOs are required to provide identification cards to all their members to identify them as enrollees in their plan. Identification cards must be approved in writing by the state. The cards must comply with all state and federal requirements.

Members must receive cards within 30 days of their enrollment in TennCare, or sooner, if the MCO contract requires a shorter timeframe.

6. Member service and clinical performance standards

MCOs must measure the percent of member calls not answered, including callers who hung up while waiting in the queue. The performance indicator for the abandonment rate is 10%, with the target being 0%. The benchmark is less than 5% of calls not answered.

In addition, the following performance objectives are in place for clinical quality of care:

- Childhood immunizations, defined as the percent of 24 month old children who have received all 12 recommended vaccines (target: 100%);
- Adolescent immunizations, defined as the percent of enrolled adolescents who turn 13 during the measurement year who have received recommended vaccines (target: 100%);
- Checkups after delivery of an infant, defined as the percent of female enrollees receiving a postpartum checkup 3-8 weeks after delivery (target: 100%);
- Cervical cancer screening, defined as the percent of enrolled women aged 21-64 who
 receive one or more pap tests in the reporting year or the two years prior to the reporting
 year (target: meeting the guidelines of the American College of Obstetricians and
 Gynecologists);
- Breast cancer screening, defined as the percent of enrolled women receiving a mammogram in the past two years (target: meeting the guidelines of the American College of Obstetricians and Gynecologists);
- HBA1c testing, defined as the percent of members aged 18-75 with a diagnosis of diabetes with one or more tests conducted during the measurement year (target: at least one test per member per year);
- EPSDT, defined as the percent of children receiving a periodic screen including all components outlined in the EPSDT Consent Decree (target: 100% screening).

7. PCP selection and assignment

MCOs must provide primary care case management services to TennCare enrollees. These services include the management of medical care and continuity of care. Primary care providers may include licensed physicians as well as registered professional nurses and physician assistants practicing in accordance with state law. For enrollees with complex medical problems, the MCO may choose to designate the enrollees' attending specialists as primary care providers. The PCP is responsible for maintaining enrollee medical records, for performance of reasonable preventive health services, for documenting emergency encounters and medically indicated follow-up, for coordinating hospital and/or institutional discharge planning, and for other services that may be specified in the MCO Contract.

To the extent feasible and appropriate, MCOs must offer each enrollee a choice of PCPs. They must also offer enrollees an opportunity to change PCPs within a time period of no greater than 12 months under normal circumstances. More frequent changes may be permitted when there is good cause.

8. Specialist referrals

MCOs must assure access to specialists for the provision of covered services. Access standards for specialists are identified in the Special Terms and Conditions for Access (See Attachment H).

9. Best Practice Network (BPN)

The Best Practice Network (BPN) is composed of Best Practice Providers (BPP). A Best Practice Provider is one (primary care, behavioral health, or dental) who has been determined by the state to have the interest, commitment, and competence to provide appropriate care for children in state custody (Part 2 B), in accordance with -----statewide Best Practice Guidelines, and who has agreed to be in the MCO network. The BPN is currently a sub-network of TennCare Select providers. One part of the agreement is to provide a medical home for these

children by maintaining all health records for the child, regardless of where the care is provided. All providers are required to forward medical records to the BPN PCP so that a comprehensive medical record can be maintained.

10. Appointment timeliness standards

Appointment timeliness standards are as stated in the Special Terms and Conditions for Access (See Attachment H).

11. Claims systems and performance standards

MCOs are required to have in place an automated claims payment system capable of accepting and processing claims submitted electronically, with the exception of certain claims that require written justification for payment (such as hysterectomy consent forms). The MCO must assure that 90% of clean claims for payment of services delivered to a TennCare enrollee are processed within 30 days of receipt of the claim. (A clean claim is defined as one for which no further written information or substantiation is required in order to make a decision on payment.) In addition, the MCO must assure that it adjudicates 99.5% of claims within 60 days of receipt. The MCO is required to contract with independent reviewers to review disputed claims in accordance with Tennessee Code Annotated, Section 56-32-226.

MCOs will be required to measure their claims payment accuracy, based upon the number of claims paid accurately upon initial submission. The target is 100%, with a benchmark of 97% accuracy upon initial submission.

B. Payment Mechanisms

1. MCC Reimbursement Methodology

(a) Managed Care Organizations (MCOs)

Payments to MCOs fall into two general categories: Administrative and Medical Reimbursement. Administrative payments are made to each MCO monthly by the TCMIS based on the number of enrollees that MCO served during the month. Payments are also made to MCOs for reimbursement of actual medical expenses incurred by TennCare enrollees on a weekly basis.

A portion of the MCOs Administrative payment is placed at risk. The terms of this arrangement include a Risk and Bonus component, placing ten percent (10%) of the administrative fee at risk and providing a Bonus potential to earn fifteen (15%) of the administrative fee for maintaining and/or meeting specified performance measures. The performance measures and percentages of Risk or Bonus associated with each are found in the Table below:

Shared Risk Initiative	Contribution to Risk	Contribution to Bonus
Medical Services Budget Target	2.0%	5.0%
Usage of Generic Drugs	2.0%	2.0%
Completion of Major Milestone for NCQA	2.0%	Not Applicable
EPSDT Compliance	2.0%	2.0%
Non-Emergency ER Visits per 1000	1.0%	2.0%
Inpatient Admissions per 1000	1.0%	4.0%

For the most part, the performance measures are benchmarked against each individual MCO's previous experience and failure to maintain or improve will impact the MCO financially. Should an MCO meet benchmarks that achieve bonus payouts, the savings realized by TennCare will more than pay for the bonus payouts.

(b) Behavioral Health Organizations (BHO)

Unlike payments to the MCOs, payments to BHOs are not made for actual medical costs, but are made using capitation rates based on actuarial review by Aon consulting. These rates are divided into age categories and priority status for each region of the state. The contractor is paid a monthly capitation payment based upon the rates and the enrollment of the plan.

East Region

Monthly payments made in this region are based on fixed capitated rates specified in the contract. This amount is calculated using the enrollee number of days for the current month and an adjustment for prior periods is made to this amount.

Non-East Region

Monthly payments made in this region are based on fixed capitation rates specified in the contract. This amount is calculated using the enrollee number of days for the current month and an adjustment for prior periods is made to this amount.

(c) Dental Benefits Manager (DBM)

Payments to the DBM are similar to those made to the MCOs in that they also fall into two categories: Administrative and Medical Reimbursement. Administrative payments are made monthly based on a contracted amount per person per month.

Payments are made on a biweekly basis for reimbursement of actual dental expenses incurred by TennCare enrollees.

(d) Pharmacy Benefits Manager (PBM)

Payments to the PBM fall into one of the following categories: Administrative, Prescription, Implementation or Call Center.

Payments made pursuant to the Administrative category are made monthly based on set fixed amounts for various administrative functions. Payments in the Prescription category are made monthly based on actual costs for prescriptions issued to TennCare enrollees. Payments in the implementation category are made monthly based on specific milestones within the PBM contract. The last category, Call Center, is for payments made to the PBM based on call center volume.

2. Federally Qualified Health Centers Reimbursement Methodology

As specified in each MCO contract, MCOs reimburse Federally Qualified Health Centers (FQHCs) either on a capitated (risk) basis considering adverse selection factors or on a cost-related basis. MCOs are also required, on at least an annual basis, to identify and report to the TennCare Bureau each FQHC with which the MCO contracts and the methodology under which the FQHC is reimbursed.

Within 60 days after the end of each quarter, FQHCs report the number of actual visits and the corresponding MCO payments for services provided to TennCare enrollees.

Upon review of these reports by the Comptroller's Office, the State makes quarterly payments to the FQHCs for the actual difference between the amount of MCO reimbursements received and the adjusted prospective payment rate for the FQHCs. In the event an FQHC does not timely report the number of visits and MCO payments received for the quarter, the State will make an estimated quarterly payment and reconcile the difference once the actual data for the quarter is received.

3. Methodology for Essential Access Hospital Payments

(a) Eligible hospitals

Hospitals eligible to receive essential access hospital payments include all hospitals licensed to operate in the State of Tennessee excluding the five (5) state mental health institutes and the six (6) critical access hospitals. The critical access hospitals receive cost-based reimbursement from the TennCare project and therefore do not have any unreimbursed TennCare costs.

(b) Allocation of the pool to segments of hospitals

The \$100 million Pool is segmented into 4 distinct parts as follows:

Essential Service Safety Net hospitals - \$50 Million

These hospitals are defined as any hospital that is both a Level 1 Trauma Center and a Regional Perinatal Center or any metropolitan public hospital that is contractually staffed and operated by a safety net hospital for the purpose of providing clinical education and access to care for the medically under served.

Children's Safety Net hospitals - \$5 Million

These hospitals are defined as any hospital licensed by the Tennessee Department of Health whose primary function is to serve children under the age of 21 years in Tennessee.

Free Standing Psychiatric hospitals - \$2 Million

These hospitals are defined as hospitals licensed by the Tennessee Department of Mental Health and Developmental Disabilities for the provision of psychiatric hospital services in Tennessee excluding the State Mental Health Institutes.

Other Essential Acute Care hospitals - \$43 Million

These hospitals include all other hospitals licensed by the Tennessee Department of Health to provide services in Tennessee excluding the critical access hospitals and state mental health institutions.

(c) Data

Calculation of the quarterly payments is based on the most current Joint Annual Report of Hospitals available at the beginning of the state fiscal year for which the quarterly payments are being made.

(d) Minimum qualifications

In order to receive a payment, the non-free standing psychiatric hospitals must be a contracted provider with TennCare Select and, where available, at least one other Managed Care Organization in the TennCare project. In order to receive a payment, the free standing psychiatric hospitals must be a contracted provider with at least one of the Behavioral Health Organizations in the TennCare project. All hospitals (unless they are capitated and accept the capitation as full reimbursement) must have unreimbursed TennCare cost.

Minimum qualification for all acute care hospitals:

Each qualifying hospital must have 13.5% or more of its total adjusted days covered by TennCare.

- OR -

A hospital may qualify if 9.5% or more of the total adjusted days are covered by TennCare and the number of adjusted days for the hospital is higher than the average number of TennCare Adjusted Days.

Minimum qualifications for Freestanding Psychiatric hospitals

At least 30% of total adjusted days are covered by TennCare.

(e) Allocation is based on an assignment of points for

- TennCare adjusted days expressed as a percent of total adjusted patient days
- Bad debt, charity, and medically indigent care expressed as a percent of total expenses

(f) Calculation of points

- (1) TennCare volume is defined as the percent of a hospital's total adjusted days that are covered by TennCare. Points are assigned based on that percent as follows:
- 1 point greater than or equal to 9.5% but less than 13.5% and the actual number of TennCare adjusted days must be greater than the average for all acute care hospitals, excluding the critical access, pediatric and safety net providers;
- 1 point greater than or equal to 13.5% and less than or equal to 24.5%;
- 2 points greater than 24.5% and less than or equal to 34.5%;
- 3 points greater that 34.5% and less than or equal to 49.5%;
- 4 points greater than 49.5%.
- (2) Bad debt, Charity and Medically Indigent BDCHMI costs as a percent of total expenses
- 0 points less than 4.5%
- 1 point greater than or equal to 4.5% and less than 9.5%
- 2 points greater than or equal to 9.5% and less than 14.5%
- 3 points greater than or equal to 14.5%

(g) Calculation of amounts of payments for hospitals

These points are then used to adjust the General Hospital Rate (GHR) based on pre-TennCare hospital reimbursement rates. The GHR rate includes all inpatient costs (operating, capital, direct education) but excludes add-ons (indirect education, MDSA, return on equity).

The GHR for Safety Net Hospitals is \$908.52. The GHR for Other Essential Access Hospitals is \$674.11. The points for each qualifying hospital are summed and then used to determine the percent of the GHR that is used to calculate the initial payment amount for each hospital.

- 7 points 100% of GHR
- 6 points 80% of GHR
- 5 points 70% of GHR
- 4 points 60% of GHR
- 3 points 50% of GHR
- 2 points 40% of GHR
- 1 point 30% of GHR

For each of the 4 pools, the appropriately weighted GHR for each qualifying hospital is multiplied by the number of adjusted TennCare days provided by the hospital. These amounts are summed for all of the hospitals that qualify for the pool. Each hospital's initial calculated amount is then adjusted to the total in the pool. This is done by multiplying the initial calculated amount for a hospital by the ratio of the total initial calculated amount for all qualifying hospitals to the total amount of the pool allocated for that group. So if the sum of the initial calculated amounts for the pediatric group is \$9 million and the total pool for children's hospitals is \$5 million, each hospital's initial calculated amount will be multiplied by \$5 million / \$9 million. The resulting values will be the amounts to be provided to the hospitals as an essential access hospital payment for the fiscal year.

(h) Payments

Hospitals are paid on a quarterly basis following the end of each quarter. The initial payment includes all quarters that have ended at the time that the payment is made. All subsequent quarterly payments are made following the end of the quarter. In order to receive a payment for the quarter, all non-free standing psychiatric hospitals must be a contracted provider with TennCare Select and, where available, at least one other Managed Care Organization, and must have contracted with TennCare Select for the entire quarter that the payment represents. In order for the free-standing psychiatric hospitals to receive a payment for the quarter, the free-standing psychiatric hospitals must be a contracted provider with at least one of the Behavioral Health Organizations.

4. Special pool payments to critical access hospitals

In accordance with the Special Terms and Conditions, the state shall make special pool payments to TennCare Critical Access Hospitals. The state's methodology for making these payments and for claiming federal participation for the payments is described below.

To qualify for payment as a Critical Access Hospital, a hospital must meet the following criteria:

It must be an acute care hospital located and licensed in the State of Tennessee.

- It must be designated as a Critical Access Hospital by the Tennessee Department of Health.
- It must contract with a managed care organization participating in TennCare.

TennCare provides reimbursement to Critical Access Hospitals under the following terms. Payments are limited to specific legislative appropriations for which federal financial participation is available. In any fiscal year where reimbursable TennCare costs incurred by Critical Access Hospitals exceed annual appropriations, equitable adjustments are made to the rates described below to cap reimbursement at the annual appropriation for which federal financial participation is available. Payments to hospitals are made through a contractual agreement with a TennCare managed care organization.

Inpatient Critical Access Hospital services include no more than 15 acute inpatient beds, although an exception to the requirement is made for swing bed hospitals. Critical Access Hospitals are allowed to have up to 25 inpatient beds that can be used interchangeably for acute or Skilled Nursing Facility (SNF) level of care, provided that no more than 15 beds are used at any one time for acute care.

Inpatient services. Effective for dates of service beginning July 1, 2002, TennCare inpatient services that are furnished by Critical Access Hospitals are reimbursed quarterly with interim per diem rates and are cost-settled at year-end. Using the Joint Annual Reports filed for the most recent year available, interim per diem rates for TennCare inpatient services are determined with consideration given to payments for TennCare services made to hospitals by managed care organizations and any special payments to hospitals. Interim rates are calculated to reimburse hospitals at a rate that will not exceed 95% of TennCare reasonable costs.

Outpatient services. Effective for dates of service beginning July 1, 2002, TennCare outpatient services that are furnished by Critical Access Hospitals will be reimbursed based on a percentage of charges with year-end cost settlements. Using the Joint Annual Reports filed for the most recent year available, interim rates for TennCare outpatient services will be determined as a percentage of charges with consideration for payments for TennCare services made to hospitals by managed care organizations and any special payments to hospitals. Interim rates will be calculated to reimburse hospitals at a rate that will not exceed 95% of TennCare reasonable costs.

For new Critical Access Hospitals that qualify after July 1, 2002, the state began reimbursement at the rates established on the first day of the calendar month after notification to the Bureau of TennCare by the hospital of its Critical Access Hospital designation. At that time, interim rates were established, and the designation was confirmed with the Department of Health.

Each Critical Access Hospital is required to maintain adequate financial and statistical records which are accurate and in sufficient detail to substantiate the cost data reported. These records must be retained for a period of not less than five years from the date of the submission of the Joint Annual Report. The provider is required to make such records available upon demand to representatives of the Bureau of TennCare or the United States Department of Health and Human Services. All hospital cost reports and Joint Annual Reports are subject to audit at any time by the Comptroller of the Treasury and the Bureau of TennCare or their designated representative.

5. Supplemental pool payments to Meharry Medical College

Under the Medicaid Section 1115 demonstration, Special Terms and Conditions, TennCare makes supplemental payments to Meharry Medical College's clinics based on the unreimbursed TennCare costs incurred by these entities.

TennCare provides federal matching funds for the Meharry Medical College state operating grant at the current rate of federal financial participation subject to available state appropriations, TennCare budget neutrality under the demonstration, and TennCare unreimbursed costs incurred by Meharry's clinics. The annual amount is allocated and paid on a regular basis to one of the Meharry Medical College clinics.

Each of the clinics operated by Meharry Medical College must contract with a managed care organization and/or behavioral health organization participating in TennCare.

Meharry provides an annual analysis of unreimbursed TennCare costs incurred by the clinics. This analysis is subjected to certain agreed-upon procedures determined by TennCare and Meharry Medical College and applied by a certified public accountant to ensure costs and related revenues are accurately reflected in the analysis. The analysis takes into consideration all revenue received for the TennCare services provided, including revenue from supplemental TennCare payments and from the Metropolitan Government of Nashville and Davidson County through a professional services agreement.

The college and its clinics are required to maintain adequate financial and statistical records, which are accurate and in sufficient detail to substantiate the cost and revenue data reported. These records must be retained for a period of not less than five years from the date of the submission of the unreimbursed cost analysis. The provider is required to make such records available upon request to representatives of the Bureau of TennCare or the United States Department of Health and Human Services. All reports are subject to audit at any time by the Comptroller of the Treasury and the Bureau of TennCare or their designated representative.

C. Encounter Data

Overview

This chapter describes encounter data reporting requirements for MCOs, BHOs, TennCare Select, the Pharmacy Benefits Manager and Dental Benefits Manager. Each of these Managed Care Contractors (MCCs) is required to submit individual encounter records for services provided to TennCare eligibles on a regular basis. Encounter data is required in order to monitor quality of care, monitor service utilization and cost trends, support rate-setting, and satisfy federal reporting requirements (see Part 6).

1. Systems requirements

To ensure the timely submission of accurate encounter data, all TennCare providers are required to maintain and operate an information system capable of capturing individual units of service interfacing with the TennCare MMIS. All vendors must successfully complete a readiness review of their information systems that is designed to ensure that their processing system satisfies the functional and informational requirements of TennCare. Each vendor has an access network established with TennCare for sharing data. Any software or additional communications network required for access is provided by the MCCs. To ensure the timely capture and reporting of data TennCare MCCs must process 99.5% of claims within 60 days of receipt. The TennCare interface standard for data transfers is via FTP, using HIPAA transaction

formats, with DVDs, CDs or 36 track compressed cartridges for backup contingency, initial file loads and TennCare selected communications.

2. Frequency

All MCCs (MCOs, BHOs, DBM, and PBM) participating in TennCare are required to submit individual encounter data generated in the process of their regular financial cycle, typically on a weekly basis. Individual encounter records for hospital, home health, professional, community health clinic services, ambulance services, dental services, pharmacy services, hospice services, and other medical services are required.

3. Format

To support the uniform reporting of encounter data all MCOs are required to utilize standardized claim formats. The required formats are:

Type of Claim
Professional
Institutional
Pental
Pharmacy

Required Format
ASC X12N 837P
ASC X12N 837I
ASC X12N 837D
NCPDP 1.1

Once claims for payment are processed, MCCs must submit encounters for individual units of service to TennCare. Generally MCC encounter files are generated as part of the standard financial cycle and submitted to TennCare, most often being received and processed concurrent with or shortly following issuance of a check from the MCC. For the MCO and BHO, required minimum data elements for encounter reporting are included in the Contractor Risk Agreement. The critical data elements for the pharmacy and dental programs are included in the contracts with the Pharmacy and Dental Benefits Managers.

4. Data integrity

Upon receipt of encounter data files, TennCare conducts several validation edits ranging from verifying that financial fields have numeric characters to verifying that required fields, such as individual identifiers (e.g., Patient Last Name, ID Number), are populated. Any error that results in a HIPAA compliance edit results in the rejection of the entire file. All seven levels of HIPAA reporting compliance are validated. In the event that edits identified as threshold edits are greater than 2%, the entire file is also rejected. The MCC is usually given 3 business days to submit a replacement file. In the unlikely event that an MCO does not comply with encounter data reporting requirements, TennCare may apply liquidated damages or other intermediate sanctions as specified in the Contractor Risk Agreement.

Part Five: Quality of Care

A. Quality Assurance and Utilization Review

1. MCO quality monitoring

The Division of Quality Oversight is responsible for monitoring and ensuring that TennCare members have access to timely, appropriate, high quality, medically necessary, covered healthcare services and experience quality health outcomes. Monitoring activities are either provided directly by Quality Oversight or in concert with TennCare contractors.

TennCare has mandated that all Managed Care Organizations (MCOs) participating in the TennCare Project be accredited by the National Committee for Quality Assurance (NCQA) by December 31, 2006. NCQA accreditation was selected because the accreditation survey process encompasses a comprehensive review of the key aspects of care and service and the overall quality of care provided by individual MCOs. The contracts of Managed Care Organizations failing to obtain NCQA accreditation, by December 31, 2006, will be terminated by the Bureau of TennCare, leaving only those MCOs providing the highest quality of care and service to serve the TennCare population.

As part of the accreditation process, the MCOs will be performing the Medicaid version of the Health Plan Employer Data and Information Set (HEDIS) and the Consumer Assessment of Health Plans Study (CAHPS Survey). HEDIS and CAHPS will allow a reliable comparison of the performance of TennCare MCOs to other Medicaid managed care health plans.

HEDIS data will be audited by a NCQA certified HEDIS auditor prior to submission to TennCare and NCQA. This data will allow TennCare to assess MCO specific performances and perform comparative analyses of TennCare to other Medicaid managed care plans throughout the country. This data will be used to identify best practices and determine opportunities for improvement among the TennCare MCOs.

The CAHPS survey tool measures health care consumers' satisfaction with the quality of care and customer service provided by their health plans. Audited HEDIS and CAHPS data is required to be submitted to TennCare annually for review and analysis. MCOs are required to report NCQA Accreditation findings, level of accreditation awarded by NCQA and any changes in accreditation status to TennCare.

2. Network access

MCOs must assure that there are an adequate number of primary care providers, specialists and other service providers who are willing and able to provide the level of care and range of services necessary to meet the medical needs of the members enrolled in their Plan. The MCOs and the Dental Benefits Manager must demonstrate their ability to provide all contracted services on a timely basis and assure accessibility to services. There are certain time/distance travel standards outlined in the Contractor Risk Agreements that must be met. The Provider Networks Unit evaluates MCO and DBM provider networks on a routine basis and where noncompliance is indicated a corrective action plan is requested.

3. BHO quality monitoring

The Tennessee Department of Mental Health and Developmental Disabilities' (TDMHDD) Office of Managed Care (OMC) is charged with monitoring and oversight of the Behavioral Health

Organizations (BHOs) participating in the TennCare Partners Program. The TennCare Bureau has also contracted with the TDMHDD to assess the effectiveness of the use of clinical best practice guidelines for adults and children receiving services through the TennCare Partners Program, and assessing the use of these best practices for children in the custody of the Tennessee Department of Children's Services (DCS) when the behavioral health services are rendered by DCS contracted providers. The Office of Managed Care shall routinely assess that these individuals are receiving medically necessary behavioral health services in accordance with these guidelines.

The Office of Managed Care's Performance Monitoring Plan details the components of monitoring and oversight that will be implemented to ensure contractual compliance, assess and promote the delivery of quality and timely mental health services, and to provide structure and means for communicating issues and outcomes to all appropriate entities. The Performance Monitoring Plan includes monitoring activities such as scheduled site visits, required BHO contract deliverables, and special focus studies targeting improvement in relevant areas of clinical care and non-clinical services.

4. External Quality Review Organization (EQRO) activities

TennCare contracts with an EQRO to support independent, external reviews of the quality of services available to enrollees in the TennCare project. The EQRO assists the Bureau of TennCare in reaching its goal of ensuring that each enrollee can access timely, high quality, medically necessary, covered healthcare services.

The EQRO provides services that are consistent with the following:

- Applicable Federal External Quality Review (EQR) regulations and protocols for Medicaid Managed Care Organizations,
- State specific requirements related to Federal court orders, including *Grier*, *John B*, and *Newberry*; and
- Contractor Risk Agreements (CRA) with TennCare Managed Care Contractors including the Managed Care Organizations, Behavioral Health Organizations, and the Dental Benefit Manager.

5. EPSDT focused efforts

The state is taking a number of steps to improve the provision of EPSDT screenings and services. MCOs participating in TennCare must conduct effective outreach and education programs; provide transportation and scheduling assistance for each eligible child's periodic examination; and conduct extensive provider education.

EPSDT screens are to be provided in accordance with the latest "American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care" periodicity schedule. Annually, the Division of Quality Oversight monitors the MCOs' performance with respect to the provision of EPSDT screens and a statistically valid sample of medical records is reviewed to measure whether or not the seven (7) required components of the screen have been performed. MCOs are required to submit corrective actions plans to address deficiencies found in any of the required screening components.

Specific performance targets have been established for EPSDT screens and incentives have been included in the CRA to encourage and maintain compliance with the performance targets.

B. Grievance and Appeal Policies

1. Eligibility Appeals

TennCare enrollees may appeal actions affecting their TennCare eligibility. Action is defined as a termination, suspension or reduction of Medicaid eligibility. Individuals applying for TennCare may appeal denials of their applications for TennCare.

The Bureau of TennCare has delegated to DHS the authority to make eligibility-related determinations, including taking final administrative action in the context of eligibility-related appeals. Accordingly, prior to January 2005, appeals related to TennCare Medicaid eligibility were processed by the Department of Human Services (DHS) and appeals concerning TennCare Standard eligibility were processed by the Bureau of TennCare. Effective January 2005, however, a new Division of Appeals and Hearings within DHS assumed responsibility, utilizing a single administrative process, for both TennCare Medicaid and TennCare Standard eligibility-related appeals.

CMS has approved a notice and appeals process for (i) the disenrollment of adult TennCare Standard enrollees and adult non-pregnant Medically Needy enrollees at the end of their year of eligibility (summarized in Attachment E to the Special Terms and Conditions) and (ii) the initial implementation of changes in coverage of TennCare benefits (summarized in Attachment F to the Special Terms and Conditions). Based on these approved processes and in accordance with applicable federal requirements, DHS has implemented the following structure for eligibility-related appeals:

- When an enrollee's eligibility for TennCare is terminated, suspended or reduced, individuals are provided at least 20-days advance notice. This notice informs the enrollee of (i) the reason for the action, (ii) the legal basis for the proposed action, (iii) the right to request a fair hearing, and (iv) the right to request continuation of benefits. Enrollees are provided 40 days from the date of the notice to request a fair hearing. Enrollees who request a fair hearing prior to the date of action will retain their TennCare benefits pending a determination that the enrollee has not raised a valid factual dispute or until the appeal is otherwise resolved, whichever comes first.
- When an individual's application for TennCare is denied, individuals are provided notice. This notice informs enrollee of (i) the reason for the denial, (ii) the legal basis for the denial, and (iii) the right to request a fair hearing. Individuals are provided 40 days from the date of the notice to request a fair hearing.
- Requests for fair hearings are only granted for those individuals who have raised a valid factual dispute related to the action taken by the State. DHS is responsible for reviewing each request for a hearing to determine if it is based on a valid factual dispute. If DHS determines that there is no indication of a valid factual dispute, DHS will send the individual a letter asking him to submit additional clarification of any issue of factual dispute on which the appeal is based within 10 days. Unless such clarification is timely received and is determined by DHS to establish a valid factual dispute, DHS will dismiss the request for a fair hearing. If DHS determines that the individual has requested a hearing based on a valid factual dispute, the case proceeds to a fair hearing.
- When an appeal is scheduled for a hearing, DHS's Office of General Counsel provides the enrollee a written Notice of Hearing. The Notice of Hearing identifies the time and location of the hearing, informs the enrollee of her right to be represented by counsel along with a statement of the legal authority under which the hearing will be held and a

short statement of the position asserted by DHS. Enrollees may represent themselves at the hearing or may retain someone to represent them at the hearing. Free or low-cost representation is often available from the local Legal Services Office. DHS provides the enrollee with a list of all Legal Services offices throughout the State of Tennessee.

2. Service and Benefit Appeals

TennCare enrollees have the right to appeal adverse actions affecting their TennCare benefits. Adverse actions include but are not limited to, delays, denials, reductions, suspensions or terminations of TennCare benefits as well as any other act or omission of the TennCare program which impairs the quality, timeliness or availability of such benefits. The Bureau of TennCare has assumed responsibility for processing service-related appeals.

The appeals processes developed by the Bureau of TennCare are based upon federal law, the notice and appeal processes approved by CMS for changes in coverage of TennCare benefits (summarized in Attachment F to the Special Terms and Conditions) and the provisions of the Grier v. Goetz Consent Decree. Notice and appeal processes include but are not limited to:

- When an adverse action is taken affecting TennCare benefits by the state, managed care entities or providers, enrollees are provided with a notice of appeal rights. The timing of the notice depends on the nature of the adverse action. For example, notice is provided to enrollees upon denials of payment for claims for services that have exceeded applicable benefit limits.
- The notice of appeal informs enrollees of (i) the type and amount of services at issue, (ii) a statement of reasons for the proposed action, (iii) the legal basis for the proposed adverse action, (iv) the right to request a fair hearing, including the right to request an expedited appeal and (v) if applicable, the right to continuation of services pending appeal. Enrollees have 30 days from the date of the notice to request a fair hearing. In circumstances when enrollees have a right to request continuation of benefits, benefits will be continued if the enrollee requests a fair hearing prior to the date of the adverse action.
- Requests for fair hearings are only granted for those individuals who have raised a valid factual dispute related to the adverse action. The TennCare Solutions Unit (TSU) will review each request for a hearing to determine if it is based on a valid factual dispute. If the enrollee fails to establish a valid factual dispute, TSU will dismiss the request for a fair hearing. If TSU determines that the individual has requested a hearing based on a valid factual dispute, the case proceeds to a fair hearing.
- When a medical service appeal is scheduled for a hearing, TennCare's Office of General Counsel provides the enrollee a written Notice of Hearing. The Notice of Hearing identifies the time and location of the hearing, informs the enrollee of her right to be represented by counsel along with a statement of the legal authority under which the hearing will be held and a short statement of the position asserted by TennCare. Enrollees may represent themselves at the hearing or may retain someone to represent them at the hearing. Free or low-cost representation is often available from the local Legal Services Office. TennCare provides the enrollee with a list of all Legal Services offices throughout the State of Tennessee.

Part Six: Administration

A. Administration and Management Systems

Overview

This chapter provides a description of the TennCare Management Information System (TCMIS), including a discussion of the system design and explanation of how the system interfaces with outside agencies and providers. In addition, this chapter will describe HIPAA compliance activities that have been completed and those scheduled to be completed during the course of the new demonstration.

The Bureau recently completed implementation of a new TCMIS. The TCMIS is maintained and operated by an outside contractor, performing as the facilities manager. The new TCMIS brings increased flexibility to better support project management as well as TennCare demonstration and reform modifications, such as multiple benefit plans and carve-out programs.

1. Information system modules

The replacement TCMIS is designed to meet the complex management and information needs of TennCare and has the capability to administer multiple benefits packages. This functionality is necessary to manage benefits service limits and optional benefit riders, (e.g. optional dental benefits and pharmacy benefits only). The replacement TCMIS also automates many existing processes, such as imaging of letters generated to recipients and providers. The new system also includes accounting functions to provide for premium collections and client reimbursement for premium and out of pocket refunds.

A description of the replacement TCMIS major functions is provided below.

(a) Eligibility

The TCMIS houses the master eligibility file for TennCare. This sub-system maintains and updates day-specific eligibility information for the TennCare Medicaid and TennCare Standard populations, as well as for SSI populations, including Medicare beneficiaries. Updates to the TennCare eligibility master file are currently received from multiple sources: DHS, DOH, DCS, SSA, DMRS and DMHDD. The eligibility subsystem is used for all functions that require eligibility and enrollment data (e.g., claims processing, enrollment processing, capitation payments, and premium collections). The system's maintenance function is to accept and maintain accurate, current and historical source data of eligibility information.

The major eligibility and enrollment functions of the TCMIS are:

- Establish and maintain a single client identifier for each person that can be associated with historical identifiers and other family members.
- Track all categories of eligibility, with begin and end dates for each category.
- Manage acceptance of Medicare, TennCare Medicaid and TennCare Standard eligibility records and updates from internal and external agencies.
- Process eligibility and maintenance updates from DHS, DCS, DMHDD, DMRS, and SSA, maintaining historical eligibility data from each.
- Use eligibility information for notice generation for re-certifying eligibility for the TennCare Standard population annually or upon a qualifying event, if needed.
- Process MCO/BHO/PBM/DBM enrollment/disenrollment.

- Assign enrollees to a Managed Care Contractor and generate MCO/BHO/PBM/DBM enrollment rosters.
- Support the balloting process, if required, to allow enrollees an opportunity to change their managed care contractor. This includes the design, printing, mailing and processing of returned ballots. (TennCare anticipates that the balloting process will be replaced by a process whereby enrollees are given an opportunity to change MCOs when they come in for their annual reverification.)
- Assure that demographic information is maintained and identifiable by data source.
- Identify persons with special needs or in special populations.
- Collect and distribute third party liability information.

The eligibility and enrollment sub-system accepts the following eligibility data:

- TennCare Medicaid and TennCare Standard eligibility data from the Department of Human Services ACCENT system.
- Patient liability information from DHS and long term care facilities.
- SSI eligibility data from the Social Security Administration.
- DCS immediate eligibility data from the Department of Children's Services (TnKIDS system).
- Breast and Cervical Cancer Treatment eligibility data from the Department of Human Services.
- Severely and/or Persistently Mentally III (SPMI) and Seriously Emotionally Disturbed (SED). Eligibility data from the Tennessee Department of Mental Health and Developmental Disabilities (MHDD).
- Buy-In eligibility data from the Centers for Medicare and Medicaid Services.

This subsystem will also interface with the federal Department of Defense, Managed Care Organizations, Behavioral Health Organizations, Pharmacy Claims Processor, Dental Benefits Manager, and the Beneficiary Data Exchange to obtain enrollee information regarding third-party resources, Medicare benefits and buy-in eligibility, and External Quality Review Organizations.

(b) Encounter data processing

The encounter data subsystem collects, validates and processes encounter data submitted by Managed Care Organizations, Behavioral Health Organizations and the state's Pharmacy and Dental Benefit Managers. These contractors must transfer applicable encounter data files to TCMIS using ASC X12N and NCPDP formats.

TCMIS validates the accuracy of CPT codes, HCPCS codes, Revenue Codes, ICD-9-CM codes and ADA-CDT codes. All encounter data also goes through several edit processes: including all seven levels of HIPAA compliance testing and additional edits for content and duplication.

(c) Claims processing

The TCMIS has the capacity to receive, track and process paper or electronic claims. TCMIS adjudicates claims from: Skilled Nursing Facilities for Level I Nursing Facility claims and Level 2 Nursing Facility claims, the Division of Mental Retardation Services for MR provider payments, Home and Community Based Services Waiver Providers, DCS, Commission on Aging, ICF/MR claims, and the Medicare Intermediary for Medicare professional cross-overs and Medicare institutional cross-overs claims. The new system receives and translates claims in accepted HIPAA transaction formats.

(d) Enrollee premium payments

The Bureau of TennCare generates premium statements to enrollees eligible under TennCare Standard. The premium amount is based on income (Federal Poverty (FPL) criteria), family size and composition. Premium payments are collected via a lock box operation and are posted to enrollee accounts as payments are received.

Upon acceptance of an eligibility record for a TennCare Standard applicant, TCMIS will generate a notice indicating the amount of premium that the applicant is required to pay, the effective date of coverage and the payment due date. If the initial payment is not received, enrollees are sent two delinquent notices, and termination of eligibility will ultimately occur if payment is not received within two months. Once the initial premium payment is paid, monthly invoices will be generated. Enrollees who have obtained eligibility and who are required to pay a monthly premium are sent two delinquent notices if payments are not received on time, and termination of eligibility will ultimately occur if payment is not received within two months. Since one of the eligibility requirements for TennCare Standard is that applicants must be current on premium payments, TCMIS will notify DHS whenever a person's eligibility is terminated in TCMIS for failure to pay premiums.

(e) Provider enrollment

The provider enrollment subsystem maintains provider numbers for Medicare crossover providers, out-of-state providers and TennCare Only providers. All providers contracting with a TennCare MCC must obtain a TennCare provider number, regardless of whether the MCC tracks or identifies the provider by an alternate number. The subsystem aggregates information from provider application and enrollment forms, provider network files submitted by MCCs, initial enrollment from the Medicare Intermediary and Carrier data, the Medicare Provider Sanction List from CMS, the CMS Clinical Laboratory Improvement Act database, Tennessee Department of Children's Services, Tennessee Department of Mental Health and Developmental Disabilities, and Tennessee Department of Health provider data. The Provider Enrollment file is used to monitor provider networks, generate provider mailings, track and report provider enrollment statistics, and for claims and encounter claims processing. Going forward, once the National Provider Identifier is implemented, each provider will be associated with a unique provider identifier, following HIPAA rules.

(f) Third Party Liability

The Third Party Liability (TPL) subsystem ensures that TennCare is the payer of last resort of services provided to TennCare enrollees. TPL information is maintained in TCMIS to provide the capability to manage cost avoidance and cost recoveries of claims paid.

2. Decision Support System

TennCare is currently implementing a Decision Support System to support management information needs and program integrity efforts. The system will provide defined reports, dashboards and analysis while also supporting ad hoc reporting needs. The project objective is to make program utilization, financial and operational data more accessible and to support informed decision making.

3. Production and ad hoc reporting

The TennCare production and ad hoc reporting systems support a variety of activities. TCMIS reporting capabilities are used to produce routine management reports, operational reports, required federal and state reports, to monitor MCC performance, and to support financial and clinical studies.

Federal reporting requirements

The federal reports listed below are produced from data stored in TCMIS and affiliated systems. A description of these reports can be found in Section D.

- Medicaid Program Budget Report CMS-37
- Quarterly Expense Report CMS-64
- Annual Report on Home and Community-Based Services Waivers CMS-372 and CMS-372(s)
- EPSDT Report CMS-416
- Quarterly Person-Specific Eligibility and Paid Claims Data CMS-2082 (MSIS)

4. MCO/BHO monitoring

TCMIS assists several TennCare Bureau divisions in completing their MCC monitoring activities, including:

- Monitoring MCC program administration.
- Monitoring enrollment growth, expenditures and cost trends.
- Monitoring provider network adequacy.
- · Monitoring quality and access to care
- Monitoring contract compliance

Additionally, the Tennessee Department of Commerce and Insurance monitors the financial solvency of the MCCs, analyzes their annual financial statements, and performs onsite audits of their claims processing for accuracy and timeliness of processing.

5. EPSDT tracking system

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program provides health screenings and treatment services to TennCare enrollees under the age of 21 to promote early detection of potentially chronic and disabling health conditions. The responsibility for providing EPSDT services to TennCare enrollees has been contracted to the MCOs, with the Quality Oversight Unit performing EPSDT monitoring activities to ensure compliance with federal EPSDT requirements.

TCMIS includes an EPSDT component to support the collection and maintenance of information related to EPSDT and immunization appointments and services. The system includes a mechanism to track whether persons are missing services and generate reminder notices about up-coming and over-due appointments. This centralized system provides TennCare with the ability to track EPSDT and immunization status as members transfer from one MCO or BHO to another.

6. HIPAA compliance

The Health Insurance Portability and Accountability Act (HIPAA), and in particular, HIPAA's Administrative Simplification (ASA), requires state Medicaid programs to protect confidentiality and security of personal health information. The ASA also requires state Medicaid programs to standardize the process for the submission and processing of Medicaid claims.

The TennCare Bureau ahs assumed responsibility for HIPAA compliance with respect to the TennCare program and its enrollees. Accordingly, the TennCare Bureau has implemented appropriate physical, technical, and administrative safeguards to ensure confidentiality and security of information relating to TennCare enrollees. The TennCare Bureau has also implemented changes to its interChange claims systems that incorporates current HIPAA transaction format standards for required transactions. This system provides configurable logging for audit purposes and supports granular definitions of access to ensure the appropriate use of data. The system also employs a flexible translator module in order to accommodate future transaction standards, including version upgrades of transaction formats and the implementation of the National Provider Identifier.

Despite these achievements, the TennCare Bureau continues to refine its current processes and policies to protect information relating to TennCare enrollees.

B. Budget Neutrality

The Bureau of TennCare is responsible for assuring that major expenditures remain within the federal financial participation cap. The TennCare Bureau's Health Informatics and Fiscal Services Division have primary responsibility for monitoring TennCare budget neutrality. The process for performing this function is that which has been laid out by CMS and is as follows:

Source: Approval letter for the new TennCare demonstration from the Centers for Medicare and Medicaid Services, June 8, 2005, Attachment B to the Special Terms and Conditions

The following describes the method by which budget neutrality will be assured under the TennCare demonstration beginning July 1, 2002. In general, Tennessee will be using a per capita cost method, and demonstration budget targets will be set on a yearly basis, with a cumulative five-year budget limit.

Individuals who are eligible under the demonstration will be one of three types: (1) those who are currently eligible under Tennessee's existing Medicaid State plan; (2) those who could be eligible for Medicaid if Tennessee amended its State plan; and (3) those who could not be eligible without section 1115 authority. Tennessee will be at risk for the per capita cost (as determined by the method described below) for current eligibles (as defined by groups 1 and 2 above) but not at risk for the number of current eligibles. By providing FFP for all current eligibles, Tennessee will not be at risk for changing economic conditions. However, by placing Tennessee at risk for the per capita costs for current eligibles, CMS assures that the demonstration expenditures do not exceed the level of expenditures had there been no demonstration. Tennessee will be at risk for both enrollment and expenditure growth for demonstration eligibles who could not be eligible without section 1115 authority (as defined by group 3 above).

Each yearly expenditure target for TennCare will be the sum of two budget components: (A) the projected cost of services by specified MEGs; and (B) the projected Disproportionate Share Hospital (DSH) adjustment. Each of these components has a distinct method for projecting

costs into the future. Administrative costs under the demonstration will be excluded from the budget neutrality formula except as explained elsewhere.

There are two steps involved in the calculation of the projected cost of services (A above) budget limit: determining baseline estimates of the number of Medicaid eligibles and the cost per eligible; and determining the method for inflating these estimates over time.

The initial per capita cost estimate will be based on the 1992 per capita costs of Medicaid eligibles, inflated to reflect SFY 2002 expenditures. That amount will be trended to cover SFY 2003 using the National Medicaid Health Expenditures trend rate. The per capita costs will be calculated for Children, Disabled, Adults over 65, and Other Adults. The 1992 and SFY 2003 monthly Per Member Per Month (PMPM) amounts for these groups and the specific growth rates for the PMPM amounts for remaining four years of the demonstration are listed below:

	PMPM Expenditures		Annual Demonstration Trend Rates			
	SFY SFY 2003/ DY-1		DY-2	DY-3	DY-4	DY-5
	1992					
Children	\$ 107.07	\$ 230.19	7.98%	7.98%	7.98%	7.98%
Disabled	\$ 339.57	\$ 730.05	7.84%	7.84%	7.84%	7.84%
Over 65	\$ 147.75	\$ 317.64	6.18%	6.18%	6.18%	6.18%
Adults	\$ 211.68	\$ 455.09	7.75%	7.75%	7.75%	7.75%

The annual limit on Medicaid expenditures will be the sum of the DSH adjustment for that year and the products of the inflated per capita cost estimate for that year times the number of Medicaid eligibles (limited to those who would have been eligible without the demonstration, including optional populations that could have been authorized under State Plan Amendments) for each of the four eligibility groups.

The DSH adjustment is based on DSH payments made by Tennessee in 1992 and calculated in accordance with current law. The DSH adjustment for the initial year of the demonstration (SFY 2003) is \$413,700,907. The DSH adjustment for each subsequent year shall be the previous demonstration year's adjustment trended by the CPI-U for that year, as published three months after the end of the demonstration year. In this manner, Tennessee will have available funding for DSH adjustments similar to other States. The calculation of the DSH adjustment will be appropriately adjusted if Congress enacts legislation which impacts the calculation of DSH allotments.

The CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memorandums or regulation with respect to the provision of services covered under this demonstration. The CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year with respect to the provision of services covered under this demonstration, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

Budget neutrality will be determined over a five-year basis. Any annual savings from budget neutrality may only be applied to an eligibility expansion or to offset demonstration costs in excess of the annual budget limits during this period. The state must submit for CMS approval a demonstration amendment requesting the expansion. In its amendment, the state must

demonstrate that the expansion is sustainable, even when the accrued savings from this fiveyear demonstration period are exhausted.

CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of an individual demonstration year, Tennessee will calculate annual expenditure targets for the completed year for each of the demonstration components. The annual component targets will be summed to calculate a target annual spending limit. This amount should be compared with the actual amount claimed for FFP. Using the below schedule as a guide, if Tennessee exceeds these targets they shall submit a corrective action plan to CMS for approval.

<u>Year</u>	Cumulative target definition	<u>Percentage</u>
Year 1	Year 1 budget neutrality cap plus	8 percent
Year 2	Years 1 and 2 combined budget neutrality cap plus	3 percent
Year 3	Years 1 through 3 combined budget neutrality cap plus	1 percent
Year 4	Years 1 through 4 combined budget neutrality cap plus	0.5 percent
Year 5	Years 1 through 5 combined budget neutrality cap plus	0 percent

The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member/months to the total. Two individuals who are eligible for two months each contribute two eligible member/months to the total, for a total of four eligible member/months.

C. Federal Financial Participation

In order to receive federal reimbursement for which states are entitled under Title XIX, TennCare shall submit quarterly reports (CMS-37 and CMS-64) to CMS as described in Section D below. These reports shall be the basis for which TennCare reports all Medicaid and TennCare administrative and service expenditures allowed under the waivers approved for the operation of TennCare.

D. Financial Reporting

1. Medicaid Program Budget Report -- CMS-37

Responsibility: Financial Operations

Frequency: Quarterly

The CMS-37 is a quarterly financial report submitted by TennCare which provides a statement of TennCare's funding requirements for a quarter and estimates matchable Medicaid and TennCare expenditures underlying assumptions for two fiscal years (FYs) -- the current FY and the budget FY. CMS makes federal funds available each quarter based on approved estimates. In order to receive federal financial participation, TennCare must certify that the requisite matching state and local funds are, or will be, available for the certified quarter. This information is supplied to CMS electronically.

2. Quarterly Expense Report -- CMS-64

Responsibility: Financial Operations

Frequency: Quarterly, within 30 days after the end of each quarter

The CMS-64 is a statement of expenditures for which states are entitled to federal reimbursement under Title XIX and which reconciles the funding advance made on the basis of the CMS-37 (discussed above) for the same quarter. TennCare reports on this form all Medicaid and TennCare administrative and service expenditures allowed under the waivers approved for the operation of TennCare. When completed, the report shows actual Medicaid and matchable TennCare expenditures made in the preceding quarter. CMS reconciles actual expenditures reported in the CMS-64 with federal funding made available for the corresponding period.

3. Actual CPE

Responsibility: Financial Operations

Frequency: Annually (fiscal year basis), within twelve months of the end of the year

TennCare reports actual hospital certified public expenditures to CMS within twelve months of the end of TennCare's fiscal year. Expenditures are based on hospital cost and revenue data that has been reviewed by the Comptroller of the Treasury.

4. Person-Specific Eligibility and Paid Claims Data

Responsibility: Information Systems

Frequency: Quarterly

TennCare submits person-specific eligibility and paid claims data to CMS electronically on a quarterly basis. Five files are included in the quarterly submission: eligibility data; inpatient claims; long term institutional care; prescription drug claims; and all other claims.

5. Annual Report on Home and Community-Based Services Waivers -- CMS-372 and/or CMS-372(s)

Responsibility: Long Term Care Unit

Frequency: Annually, within 180 days of the end of the waiver year

TennCare submits a separate CMS-372/CMS-372(s) for each of its Home and Community Based Services Waiver Programs: the Arlington Home and Community Based Services Waiver for the Mentally Retarded; the Home and Community Based Services Waiver for the Mentally Retarded; the Home and Community Based Services Waiver for the Elderly and Disabled; and the ADAPT Home and Community Based Services Waiver. These reports are used by CMS to compare the actual number of services and expenditures incurred under the waiver with the original estimates.

Attachments

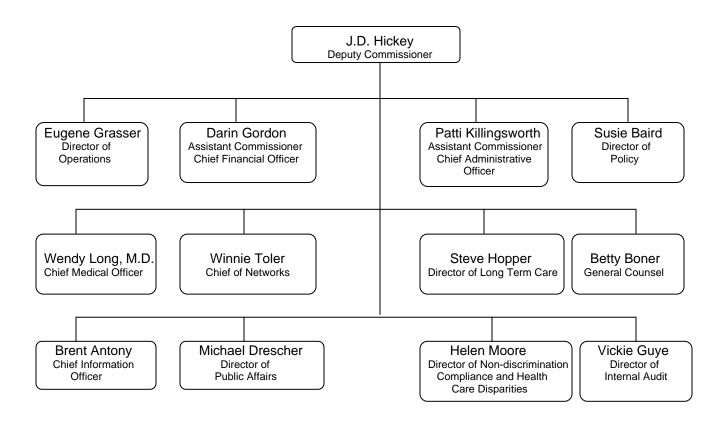
Attachment

A Bureau of TennCare Organization (Chart
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- **B** Medically Needy Qualifying Diagnoses
- C TennCare Benefits for Medicare Beneficiaries
- D List of Current Managed Care Contractors (MCCs)
- E Hardship Criteria for MCO Changes
- F Helpful Telephone Numbers
- **G** TennCare Physical and Behavioral Health Benefits
- **H** Special Terms and Conditions for Access

Attachment A

Bureau of TennCare Organization Chart



Attachment B

Qualifying Medical Conditions Used to Determine Medical Eligibility

ш	Alpha-1-Antitrypsin Deficiency		Galactosemia 2/1.1
	277.6		Hamman-Rich Disease 516.3
	ALS 335.20		Heart Valve Replacement V42.2
	Alzheimer's 331.0		Hepatitis C
	Arrhythmias 426-426.9, 427-427.9		070.41, 070.44, 070.51, 070.54
	Arthrogryposis 728.3		HIV/AIDS
	Asbestosis 501		042, 079.53, 136.3, 176.0-176.9
	Ataxia Telangiectasia 334.8		Huntington's Chorea 333.4
	Autism 299.0, 299.1, 299.8, 299.9		Hydrocephalus 742.3
	Bipolar Disorders		Kidney Failure, with dialysis
	296.1, 296.3, 296.4, 296.5, 296.6,		584.5-584.9, 585, 586
	296.7, 296.8-296.89		Lead Poisoning 961.2, 984.0-
	Cancer, with active treatment in		984.9
	past 12 months (includes		Leukodystrophies 330.0
	Hodgkin's Disease, leukemia, lymphoblastoma, lymphoma,		Lipidosis 272.7
	malignant tumor, melanoma, and		Maple Syrup Urine Disease 270.3
	sarcoma) 140-149,150-159,160-		Marfan's Syndrome 759.82
	165, 170-172, 174-176, 179-189,		Mucopolysaccharidosis 277.5 (types 1-6)
	190-197, 198-199, 200-208		Multiple Sclerosis 340
	Cardiac Pacemakers	_	Muscular Dystrophies
	V45.0, V45.00-V45.09	_	359.0, 359.1,359.2, 359.3
	Cardiomyopathy 425, 425.0-425.9		Myasthenia Gravis 358.0
	Cerebral Palsy 343, 343.0-343.9		Neurofibromatosis
	Cerebrovascular Accidents	_	237.70, 237.71,237.72
	(Thrombosis/ Hemorrhage)		Prader-Willi Syndrome 759.81
	430, 431, 432, 432.0-432.9,		Prune Belly Syndrome 756.71
	433.0-433.9, 434, 434.1-434.9, 436		Spina Bifida 741.0-741.9
	Chronic Obstructive Pulmonary		Osteogenesis Imperfecta 756.51
	Disease (COPD)		Parkinson's Disease 332.0, 333.0
_	496, 491.2-491.9, 492.0, 492.8		Phenylketonuria (PKU) 270.1
	Chronic Pancreatitis 577.1		Polyarteritis Nodosa 446.0
	Cirrhosis of the Liver 571.5, 571.6		Polycystic Renal Disease
	Coagulation Defects (Hemophilias,		753.12-753.14
	Christmas Disease, and other		Psychotic Disorders
	clotting factor disorders) 286.0- 286.9		(including Schizophrenia)
			295.0-295.9, 296.0-296.9, 297.0-
_	Congenital Adrenal Hyperplasia 255.2		297.9, 298.0-298.9, 299.0-299.9
	Congenital Heart Disease		Quadriplegia 344.00-344.09
_	745.0-745.9, 746.0-746.9, 747.0-		Rheumatic Heart Disease
	747.49		391.0-391.9, 392.0-392.9, 393,
	Congenital Hypothyroidism 243		394.0, 394.1, 395.0-395.9, 396.0-
	Congestive Heart Failure 428.0-		396.9, 397.0-397.9, 398.0-398.99
_	428.9		Rheumatoid Arthritis 714.0-714.89
	Coronary Artery Disease		Scleroderma 710.1
	(Myocardial Infarctions, Open		Sickle Cell Disease 282.60-286.69 Still's Disease 714.30
	Heart Surgery) 410.0-410.9,		
	411.0-411.89, 412, 413.0-413.9,	<u> </u>	Syringomyelia 336.0 Systemic Lupus Erythematosis
	414.0-414.9	_	710.0
<u> </u>	Crohn's Disease 555.0-555.9		Thalassemia Major 282.4
	Cystic Fibrosis 277.0, 277.01		Traumatic Brain Injury
	Demyelinating Diseases 340, 341.0-	_	850.4, 851.0-851.9
_	341.9		Tuberculosis
	Diabetes, Type 1, with comorbidity;	_	011.0-011.9, 012.0-012.8, 013.0-
	Juvenile Diabetes 250.1-250.9		013.9, 014.0-014.8, 015.0-015.9,
	Down Syndrome 758.0		016.0-016.9, 017.0-017.9, 018.0-
	Epilepsy 345.0-345.9		018.9
	Esophageal Varicies 456.0, 456.1,		Ulcerative Colitis 556.0-556.9
	456.2		Wilson's Disease 275.1
	Fetal Alcohol Syndrome 760.71	<u>O</u> rg	an Transplant
	Fragile X-Syndrome 759.83		Bone Marrow V42.81

Cornea V42.5 Heart V42.1 Heart Valve V42.2, V43.3 Intestines V42.84 Kidney V42.0 □ Liver V42.7 ☐ Lung V42.6 ☐ Pancreas V42.83

33572, 33510-33516

Attachment C

TennCare Benefits for Medicare Beneficiaries

Categories	Who is in this category?	Is this person eligible for TennCare MCO, BHO, and PBM services?	Does TennCare pay this person's Medicare cost- sharing?	Does this person have TennCare cost-sharing?	Is the person eligible for TennCare reimbursed long-term care?
"Categorically needy" Medicaid/Medicare dual eligibles (includes QMB duals)	People who have Medicare and who have also qualified for Medicaid in a continuing category (e.g., SSI or TANF)	Yes*, with pharmacy benefits for adults	Yes	Yes, for pharmacy only	Yes, if determined financially and medically eligible
QMB onlys	People with Medicare but not Medicaid and incomes <100% poverty	No	Yes	Not applicable (person is not on TennCare)	No
SLMB onlys	People with Medicare but not Medicaid and incomes <120% poverty	No	Yes	Not applicable (person is not on TennCare)	No
QDWI onlys	Disabled working people with Medicare but not Medicaid and incomes <200% poverty	No	Yes	No (person is not on TennCare)	No

^{*}Medicare is primary payor. TennCare coverage is limited to items that TennCare covers but Medicare does not (e.g., non-emergency transportation, mental health case management, etc

Attachment D

List of Current Managed Care Contractors (MCCs)

Managed Care Organizations (MCOs)

Better Health Plans

300 Oxford Drive Monroeville, PA 15146-2356 (412) 858-4000

BlueCare

801 Pine Street Chattanooga, TN 37402-2555 (423) 752-6767

John Deere Health Care

Executive Tower I 408 North Cedar Bluff Road Suite 400 Knoxville, TN 37923 (865) 769-1559

TLC Family Care Healthplan

P.O. Box 49 Memphis, TN 38101 (901) 725-7100

Preferred Health Partnership (PHP)

1420 Centerpoint Blvd. Knoxville, TN 37932 (865) 470-7470

UAHC Health Plan

1991 Corporate Avenue 5th Floor Memphis, TN 38132 (901) 346-0064

Windsor Health Plan of TN, Inc.

215 Centerview Drive Suite 300 Brentwood, TN 37027 (615) 782-7812

Volunteer State Health Plan

801 Pine Street Chattanooga, TN 37402-2555 (423) 752-6767

Behavioral Health Organizations (BHOs)

Premier Behavioral Systems of Tennessee and Tennessee Behavioral Health, Inc. 222 Second Avenue North, Suite 220 Nashville, TN 37201 (615) 313-4549

Dental Benefits Manager (DBM)

Doral Dental of Tennessee, LLC 12121 North Corporate Parkway Mequon, Wisconsin 53092 (262) 241-7140

Pharmacy Benefits Manager (PBM)

First Health Services Corporation 4300 Cox Road Glen Allen, VA 23060 1-800-884-2822

Attachment E

Medical Hardship Criteria for MCO Changes

The following criteria must be met to direct a hardship MCO change. If these criteria are not met, and the enrollee has ongoing concerns about their PCP or specialty care, a service appeal will be initiated to work with their current plan, resolve the concerns, and ensure appropriate care is provided. Deficiencies in MCO networks will be communicated to contract compliance and quality oversight units for review and assessment of appropriate sanctions or damages. An enrollee, for whom a hardship MCO change is denied, will be granted an ALJ hearing if they desire, regardless of whether or not a service appeal is in process.

Hardship Criteria:

- 1. An enrollee has a medical condition that requires complex, extensive and ongoing care.
- 2. Enrollee's PCP and/or specialist dropped from the enrollee's current MCO network and are refusing continuation of care to the enrollee under their current MCO.
- The ongoing medical condition of the enrollee is such that another physician or provider with appropriate expertise would be unable to take over their care without significant and negative impact on their condition
- 4. Current MCO has been unable to negotiate continued care for this enrollee with current PCP and/or specialist.
- 5. Current provider is in network for one or more alternate MCO.
- 6. Alternate MCO is available to enrolled new members (i.e. has not given notice of withdrawal from TennCare, is not in receivership, and is not at member capacity for region in question).

Hardship MCO change will NOT be granted in the following situations:

- 1. Enrollee is unhappy with current plan or PCP, but no hardship medical situation exists.
- 2. Current MCO has deficiencies in its network of providers.
- 3. Enrollee is unhappy with a current PCP or other providers, and has refused alternative PCP or provider choices offered by MCO.
- 4. Enrollee is concerned that a current provider might drop out of the plan in the future.
- 5. Medicare recipients who (with the exception of pharmacy) may utilize their choice of providers, regardless of network affiliation.

Routine MCO hardship changes will be directed or referred to the TennCare Information Line to process.

Examples of routine MCO hardship changes allowed under TennCare rules include:

- 1. MCO change requested within 90-days of initial assignment to a MCO.
- 2. MCO changes requested because all immediate family members were not assigned to the same plan.
- 3. When an enrollee changes place of residence, thus moving out of a plan's service area.
- 4. When an administrative error has occurred in assigning an enrollee to a plan not serving their geographic area.

Attachment F

Helpful Telephone Numbers

Family Assistance Service Center 1-866-311-4287 (743-2000 in the Nashville area)

TennCare TTY Information Line for persons with speech & hearing impairments 1-800-772-7647 (313-9240)

TennCare Spanish-speaking Information Line 1-800-254-7568 (337-7568 in the Nashville area)

TennCare Consumer Advocacy Line 1-800-722-7474 (313-9972 in the Nashville area)

TennCare Partners Advocacy Line 1-800-758-1638 (242-7339 in the Nashville area)

Statewide Mental Health Crisis Line 1-800-809-9957

TennCare Solutions Unit (TSU) 1-800-878-3192 (253-4473 in the Nashville area)

Bureau of TennCare Office 1-800-342-3145 (507-6000 in the Nashville area)

TennCare Fraud and Abuse Line 1-800-433-3982 FAX (615) 532-7509

E-mail address: TennCarefraud@state.tn.us

Bureau of TennCare website: www.state.tn.us/tenncare

Attachment G

TennCare Physical & Behavioral Health Benefits

[Note: **Both** = coverage of service/item the same for both children and adults.]

	BENEFIT
	See Emergency Air and Ground Transportation, Non-Emergency Ambulance Transportation, and Non-Emergency Transportation.
Bariatric Surgery, defined as	Both: Covered as medically necessary and in accordance with clinical guidelines established by the Bureau of TennCare.
	Under age 21: Covered as medically necessary. Age 21 and older: Not covered.
	Both: Covered as medically necessary.
[defined as care provided in a nursing facility after a hospitalization]	Under age 21: Upon receipt of proof that an enrollee has incurred medically necessary expenses related to convalescent care, TennCare shall pay for up to and including the 100 th day of confinement during any calendar year for convalescent facility room, board, and general nursing care, provided that: (A) a physician recommends confinement for convalescence; (B) the enrollee is under the continuous care of a physician during the entire period of convalescence; and (C) the confinement is required for other than custodial care.
	Age 21 and older: Not covered. Under age 21: Preventive, diagnostic and treatment services for enrollees
[defined at 42 CFR § 440.100]	covered as medically necessary. Dental services under EPSDT, including dental screens, are provided in accordance with the state's periodicity scheduled after consultation with recognized dental organizations and at other intervals as medically necessary.
	Orthodontic services must be prior approved and are limited to individuals under age 21 requiring these services: (1) because of a severe handicapping malocclusion or another developmental anomaly or injury resulting in severe misalignment or severe handicapping malocclusion of teeth, documented by at least 28 points on the Salzmann Scale, or any other method that is approved by TennCare; or (2) following repair of an enrollee's cleft palate. Orthodontic treatment will not be authorized for cosmetic purposes. Orthodontic treatment will be paid for by TennCare only as long as the individual remains eligible for TennCare. If the orthodontic treatment plan is approved prior to the enrollee's attaining 20 ½ years of age, and treatment is initiated prior to the enrollee's attaining 21 years of age, such treatment may continue as long as the enrollee remains eligible for TennCare.
	The MCO is responsible for the provision of transportation to and from covered dental services, as well as the medical and anesthesia services related to the covered dental services.
	Age 21 and older: Not covered, except for orthodontic services when a treatment plan was prior approved prior to the enrollee's obtaining 20 ½ years of age, and treatment initiated prior to the enrollee's attaining 21 years of age; such treatment may continue as long as the enrollee remains

SERVICE	BENEFIT
	eligible for TennCare.
Durable Medical Equipment [defined at 42 CFR § 440.70(b)(3) and 42 CFR § 440.120(c)]	Both: Covered as medically necessary.
Emergency Air and Ground Ambulance Transportation [defined at 42 CFR § 440.170(a)(1) and (3)]	Both: Covered as medically necessary.
Preventive, Diagnostic and Treatment Services for Persons Under age 21	Under age 21: Screening and interperiodic screening covered in accordance with federal regulations. (Interperiodic screens are screens in between regular checkups which are covered if a parent or caregiver suspects there may be a problem.)
	Diagnostic and follow-up treatment services covered as medically necessary and in accordance with federal regulations.
	The periodicity schedule for child health screens is that set forth in the latest "American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care." All components of the screens must be consistent with the latest "American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care."
Home Health Care [defined at	Age 21 and older: Not applicable. Both: Covered as medically necessary.
42 CFR § 440.70(a), (b), (c), and (e)]	All home health care must be delivered by a licensed Home Health Agency, as defined by 42 CFR §440.70.
	A home health visit includes any of the following: Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services, and Home Health Aide.
Hospice Care [defined at 42 CFR Part 418]	Both: Covered as medically necessary. Must be provided by an organization certified pursuant to Medicare Hospice requirements.
Inpatient and Outpatient Substance Abuse Benefits [defined as services for the treatment of substance abuse that are provided (a) in an inpatient hospital (as defined at 42 CFR § 440.10) or (b) as outpatient hospital services	Under age 21: Covered as medically necessary. Age 21 and older: Covered as medically necessary, with a maximum lifetime limitation of 10 detoxification days and \$30,000 in substance abuse benefits (inpatient, residential, and outpatient). Persons who are determined to be Severely and/or Persistently Mentally III are exempt from these lifetime limitations. When medically appropriate and cost effective as determined by the BHO,
(see 42 CFR § 440.20(a)]	services in a licensed substance abuse residential treatment facility may be substituted for inpatient substance abuse services.
Inpatient Hospital Services [defined at 42 CFR § 440.10]	Both: Covered as medically necessary. MCO may conduct preadmission and concurrent reviews.
	Age 21 and older: Inpatient Rehabilitation Facilities services may be covered when determined to be a cost effective alternative by the MCO.
Inpatient Rehabilitation Facility Services	See Inpatient Hospital Services.
Lab and X-Ray Services [defined at 42 CFR § 440.30]	Both: Covered as medically necessary.
Medical Supplies [defined at 42 CFR § 440.70(b)(3)]	Both: Covered as medically necessary.
Mental Health Case Management Services [defined as services rendered	Both: Covered as medically necessary.

SERVICE	BENEFIT
to support outpatient mental health clinical services]	
Mental Health Crisis Services [defined as services rendered to alleviate a psychiatric emergency]	Both: Covered as medically necessary.
Methadone Clinic Services	Under age 21: Covered as medically necessary.
[defined as services provided	Age 21 and older: Not covered.
by a methadone clinic]	
Non-Emergency Ambulance Transportation [defined at 42 CFR § 440.170(a)(1) and (3)]	Both: Covered as medically necessary.
Non-Emergency Transportation	Both: Covered as medically necessary for enrollees lacking accessible transportation for covered services.
[defined at 42 CFR § 440.170(a)(1) and (3)]	The travel to access primary care and dental services must meet the requirements of the TennCare demonstration project terms and conditions. The availability of specialty services as related to travel distance should meet the usual and customary standards for the community. However, in the event the MCO is unable to negotiate such an arrangement for an enrollee, transportation must be provided regardless of whether or not the enrollee has access to transportation.
	Under age 21: If the enrollee is a minor child, transportation must be provided for the child and an accompanying adult. However, transportation for a minor child shall not be denied pursuant to any policy which poses a blanket restriction due to enrollee's age or lack of parental accompaniment. Any decision to deny transportation of a child due to an enrollee's age or lack of parental accompaniment must be made on a case-by-case basis and must be based on the individual facts surrounding the request. As with any denial, all notices and actions must be in accordance with the appeal process.
	Tennessee recognizes the "mature minor exception" to permission for medical treatment.
	The provision of transportation to and from covered dental services is the responsibility of the MCO.
Occupational Therapy [defined at 42 CFR § 440.110(b)]	Under age 21: Covered as medically necessary, by a Licensed Occupational Therapist, to restore, improve, or stabilize or ameliorate impaired functions.
	Age 21 and older: Covered as medically necessary, by a Licensed Occupational Therapist, to restore, improve, or stabilize impaired functions.
Organ and Tissue Transplant	Under age 21: Covered as medically necessary.
Services and Donor Organ/Tissue Procurement Services [defined as the	Age 21 and older: Covered as medically necessary when coverable by Medicare.
transfer of an organ or tissue from one individual to another]	Both: Experimental or investigational transplants are not covered for any enrollee.
Outpatient Hospital Services [defined at 42 CFR § 440.20(a)]	Both: Covered as medically necessary.
Outpatient Mental Health Services (including physician	Both: Covered as medically necessary.

SERVICE	BENEFIT
services) [defined at 42 CFR § 440.20(a), 42 CFR § 440.50, and 42 CFR § 440.90]	
Pharmacy Services [defined at 42 CFR § 440.120(a) and	Under age 21: Covered as medically necessary. Certain drugs (known as DESI, LTE, IRS drugs) are excluded from coverage.
obtained directly from an ambulatory retail pharmacy setting, outpatient hospital pharmacy, mail order pharmacy or those administered to a long-term care facility (nursing facility) resident]	Pharmacy services are the responsibility of the PBM, except for pharmaceuticals supplied and administered in a doctor's office. For persons who are not dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor's office are the responsibility of the MCO. For persons who are dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor's office are the responsibility of the MCO if not covered by Medicare.
	Age 21 and older with TennCare Medicaid: Covered as medically necessary subject to the limitations below. Certain drugs (known as DESI, LTE, IRS drugs) are excluded form coverage.
	Pharmacy services are the responsibility of the PBM, except for pharmaceuticals supplied and administered in a doctor's office. For persons who are not dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor's office are the responsibility of the MCO. For persons who are dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor's office are not covered by TennCare.
	(A) Pharmacy services for individuals receiving TennCare-reimbursed services in a Nursing Facility, Intermediate Care Facility for the Mentally Retarded, or a Home and Community Based Services waiver have no quantity limits on the number of prescriptions per month.
	(B) Subject to (A) above, pharmacy services for Medicaid adults age 21 and older are limited to five (5) prescriptions and/or refills per enrollee per month, of which no more than two (2) of the five (5) can be brand name drugs. Additional drugs for individuals in (B) shall not be covered.
	Prescriptions shall be counted beginning on the first of each calendar month. Each prescription and/or refill counts as one (1). A prescription or refill can be for no more than a thirty-one (31) day supply.
	The Bureau of TennCare shall maintain a "Pharmacy Short List" of pharmacy services which shall not count against such limit. The Pharmacy Short List may be modified at the discretion of the Bureau of TennCare. The most current version of the Pharmacy Short List will be made available to enrollees via the internet from the TennCare website and upon request by mail through the DHS Family Service Assistance Centers. Only drugs that are specified on the version of the Pharmacy Short List that is available on the TennCare website located on the World Wide Web at www.state.tn.us/tenncare and indicated as current as of the date of service shall be considered exempt from applicable pharmacy limits.
(continue)	Unless specified on the version of the Pharmacy Short List which is current as of the date of the pharmacy service, pharmacy services in excess of five (5) prescriptions and/or refills per enrollee per month or two (2) brand name drugs per enrollee per month are non-covered services.
	(C) Over-the-counter drugs for Medicaid adults are not covered even if the enrollee has a prescription for such service, except for prenatal vitamins for pregnant women.

SERVICE	BENEFIT
	Age 21 and older with TennCare Standard: Not covered.
Physical Therapy [defined at 42 CFR § 440.110(a)]	Under age 21: Covered as medically necessary, by a Licensed Physical Therapist, to restore, improve, ameliorate, or stabilized impaired functions. Age 21 and older: Covered as medically necessary, by a Licensed
	Physical Therapist, to restore, improve, or stabilized impaired functions.
Physician Inpatient Services	Both: Covered as medically necessary.
[defined at 42 CFR § 440.50]	Hadanana M. Carrand as madically assessment
Physician Outpatient Services/Community Health Clinics/Other Clinic Services	Under age 21: Covered as medically necessary. Age 21 and older: Covered as medically necessary, except see
[defined at 42 CFR §	Methadone Clinic Services.
440.20(b), 42 CFR § 440.50, and 42 CFR § 440.90]	Services provided by a Primary Care Provider when the enrollee has a primary behavioral health diagnosis (ICD-9CM 290.xx – 319.xx) are the responsibility of the MCO.
	Medical evaluations provided by a neurologist, as approved by the MCO, and/or an emergency room provider to establish a primary behavioral health diagnosis are the responsibility of the MCO.
Private Duty Nursing [defined at 42 CFR § 440.80]	Both: Covered as medically necessary when prescribed by an attending physician for treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative.
Psychiatric Inpatient Facility	Both: Covered as medically necessary.
Services [defined at 42 CFR §	Preadmission and concurrent reviews by the MCC are allowed.
441, Subparts C and D and including services for	, and the second
persons of all ages]	
Psychiatric Pharmacy	See Pharmacy Services
Services	·
Psychiatric Physician	Both: Covered as medically necessary.
Inpatient Services [defined at 42 CFR § 440.50]	
Psychiatric Physician	See Outpatient Mental Health Services
Outpatient Services	Soo Supation Worthan Found Solvisos
Psychiatric Rehabilitation	Both: Covered as medically necessary.
Services [defined as	
psychiatric services	
delivered in accordance with 42 CFR § 440.130(d)]	
Psychiatric Residential Treatment Services [defined	Both: Covered as medically necessary.
at 42 CFR § 483.352] and	
including services for	
persons of all ages Reconstructive Breast	Roth: Covered in accordance with Tonn, Code Ann. & 56.7.2507 which
Surgery [defined in	Both: Covered in accordance with Tenn. Code Ann. § 56-7-2507 which requires coverage of all stages of reconstructive breast surgery on a
accordance with Tenn. Code	diseased breast as a result of a mastectomy as well as any surgical
Ann. § 56-7-2507]	procedure on the non-diseased breast deemed necessary to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.
Rehabilitation Services	See Inpatient Rehabilitation Facility, Occupational Therapy, Physical

SERVICE	BENEFIT
	Therapy, and Speech Therapy.
Renal Dialysis Clinic Services [defined at 42 CFR § 440.90]	Both: Covered as medically necessary. Generally limited to the beginning 90-day period prior to the enrollee's becoming eligible for coverage by the Medicare program.
Sitter Services [defined as nursing services provided in the hospital by a nurse who is not an employee of the hospital]	 Under age 21: Covered as medically necessary when a sitter who is not a relative is needed for an enrollee who is confined to a hospital as a bed patient. Certification must be made by a network physician that an R.N. or L.P.N. is needed and neither is available. Age 21 and older: Not covered.
Speech Therapy [defined at 42 CFR § 440.110(c)]	Under age 21: Covered as medically necessary, by a Licensed Speech Therapist to restore, improve, stabilize, or ameliorate impaired functions. Age 21 and older: Covered as medically necessary as long as there is continued medical progress, by a Licensed Speech Therapist to restore speech after a loss or impairment.
Transportation	See Emergency Air and Ground Transportation, Non-Emergency Ambulance Transportation, and Non-Emergency Transportation.
Vision Services [defined as services to treat	Under age 21: Preventive, diagnostic, and treatment services (including eyeglasses) are covered as medically necessary.
conditions of the eyes]	Age 21 and older: Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of the refractive state) is covered. Routine, periodic assessment, evaluation or screening of normal eyes, and examinations for the purpose of prescribing, fitting, or changing eyeglasses and/or contact lenses are not covered.
	The first pair of cataract glasses or contact lens/lenses following cataract surgery is covered for adults.

Attachment H

Special Terms and Conditions for Access

Source: Approval letter for the new TennCare waiver from the Centers for Medicare and Medicaid Services, May 30, 2002

In general, contractors shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hour-a-day, 7-day-a-week basis. At a minimum this shall include:

Primary Care Physician or Extender:

- (a) Distance/Time Rural: 30 miles or 30 minutes
- (b) Distance/Time Urban: 20 miles or 30 minutes
- (c) Patient Load: 2,500 or less for physician; one-half this for a physician extender.
- (d) Appointment/Waiting Times: Usual and customary practice (see definition below), not to exceed 3 weeks from the date of a patient's request for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.
- (e) Documentation/Tracking requirements:

Documentation -- Plans must have a system in place to document appointment scheduling times. The State must utilize statistically valid sampling methods for monitoring compliance with appointment/waiting time standards as part of the survey required in special term and condition 4.

Tracking -- Plans must have a system in place to document the exchange of client information if a provider, other than the primary care provider (i.e., school-based clinic or health department clinic), provides health care.

Specialty Care and Emergency Care:

Referral appointment to specialists (e.g., specialty physician services, hospice care, home health care, substance abuse treatment, rehabilitation services, etc.) shall not exceed 30 days for routine care or 48 hours for urgent care. All emergency care is immediate, at the nearest facility available, regardless of contracts. Waiting times shall not exceed 45 minutes.

Hospitals:

Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.

General Dental Services:

Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community standards and documentation will apply.

Appointment/Waiting Times: Usual and customary note to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

General Optometry Services:

Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community standards and documentation will apply.

Appointment/Waiting Times: Usual and customary note to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

Pharmacy Services:

Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community standards and documentation will apply.

Lab and X-Ray Services:

Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community standards and documentation will apply.

Appointment/Waiting Times: Usual and customary note to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

Other:

All other services not specified here shall meet the usual and customary standards for the community.

<u>Definition of "Usual and Customary":</u> access that is equal to or greater than the currently existing practice in the fee-for-service system.

Guidelines for State Monitoring of Plans

- The State will require, by contract, that Plans meet certain State-specified standards for Internal Quality Assurance Programs (QAPs) as required in 42 CFR 434.
- The State will monitor, on a periodic or continuous basis (but no less often than every 12 months), Plans' adherence to these standards, through the following mechanism: review of each plan's written QAP, review of numerical data and/or narrative reports describing clinical and related information on health services and outcomes, and on-site monitoring of the implementation of the QAP standards.
- Recipient access to care will be monitored through the following State activities: periodic
 comparison of the number and types of providers before and after the demonstration,
 periodic surveys which contain questions concerning recipient access to services,
 measurement of waiting periods to obtain health care services, and measurement of
 referral rates to specialists.

Guidelines for Plan Monitoring of Providers

- Plans will require, by contract, that providers meet specified standards as required by the State contract.
- Plans will monitor, on a periodic or continuous basis, providers' adherence to these standards, and recipient access to care.